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CONFERENCE COMMITTEE SUBSTITUTE

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

SENATE BILL NO. 127

AN ACT

To repeal sections 208.146, 208.151, 208.152, 208.895, and 660.315, RSMo, and to enact in lieu thereof eight new sections relating to public assistance benefits.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 208.146, 208.151, 208.152, 208.895, and 660.315, RSMo, are repealed and eight new sections enacted in lieu thereof, to be known as sections 208.146, 208.151, 208.152, 208.240, 208.895, 208.990, 208.995, and 660.315, to read as follows:

208.146. 1. The program established under this section shall be known as the "Ticket to Work Health Assurance Program". Subject to appropriations and in accordance with the federal Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), Public Law 106-170, the medical assistance provided for in section 208.151 may be paid for a person who is employed and who:

(1) Except for earnings, meets the definition of disabled under the Supplemental Security Income Program or meets the definition of an employed individual with a medically improved disability under TWWIIA;

(2) Has earned income, as defined in subsection 2 of this

section;

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

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

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

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

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

individuals under subdivision (24) of subsection 1 of section 208.151 except for:

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

(b) Independent living accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed five thousand dollars per year. For purposes of this section, an "independent living account" means an account established and maintained to provide savings for transportation, housing, home modification, and personal care services and assistive devices associated with such person's disability.

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

(a) All earned income of the disabled worker;

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

(c) A twenty dollar standard deduction;

(d) Health insurance premiums;

(e) A seventy-five dollar a month standard deduction for the disabled worker's dental and optical insurance when the total dental and optical insurance premiums are less than seventy-five dollars;

(f) All Supplemental Security Income payments, and the first fifty dollars of SSDI payments;

(g) A standard deduction for impairment-related employment

expenses equal to one-half of the disabled worker's earned income.

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

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

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

(3) For a person whose gross income equals or exceeds two hundred percent but less than two hundred fifty percent of the federal poverty level, five percent of income at two hundred percent of the federal poverty level;

(4) For a person whose gross income equals or exceeds two hundred fifty percent up to and including three hundred percent of the federal poverty level, six percent of income at two hundred fifty percent of the federal poverty level.

5. Recipients of services through this program shall report any change in income or household size within ten days of the occurrence of such change. An increase in premiums resulting from a reported change in income or household size shall be effective with the next premium invoice that is mailed to a person after due process requirements have been met. A decrease

in premiums shall be effective the first day of the month immediately following the month in which the change is reported.

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

7. The provisions of this section shall expire **[**six years after**]** August 28, **[**2007**]** 2019.

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

(1) All participants receiving state supplemental payments for the aged, blind and disabled;

(2) All participants receiving aid to families with dependent children benefits, including all persons under nineteen years of age who would be classified as dependent children except for the requirements of subdivision (1) of subsection 1 of section 208.040. Participants eligible under this subdivision who are participating in drug court, as defined in section 478.001, shall have their eligibility automatically extended sixty days from the time their dependent child is removed from

the custody of the participant, subject to approval of the Centers for Medicare and Medicaid Services;

(3) All participants receiving blind pension benefits;

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

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

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

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

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

(9) All persons who were participants receiving old age

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

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

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

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

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

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of

age, the family support division shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency. As necessary to provide MO HealthNet coverage under this subdivision, the department of social services may revise the state 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 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 MO HealthNet benefits under this section on the date of the child's birth shall be deemed to have applied for 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 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 MO HealthNet benefits pursuant to subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for 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 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 MO HealthNet benefits under subdivision (12), (13) or (14) of this subsection 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 eligibility specialists to process applications for MO HealthNet benefits at the site of a health care provider, if the health care provider requests the placement of such eligibility specialists and reimburses the division for the expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment of such eligibility specialists. The division may provide a health care provider with a part-time or temporary eligibility specialist at the site of a health care provider if the health care provider requests the placement of such an 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 an eligibility specialist. The division may seek to employ such eligibility specialists who are otherwise qualified for such positions and who are current or former welfare participants. The division may consider training such current or former welfare participants as eligibility specialists for this program;

(20) Pregnant women who are eligible for, have applied for and have received 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 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 or chapter 205 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 intellectual disability and developmental disability 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 MO HealthNet-eligible high-risk mothers and enroll them in the state's MO HealthNet program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who participate in the 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 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;

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

(24) (a) All persons who would be determined to be eligible for old age assistance benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the 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 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 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) Effective August 28, 2013, persons who are **[**independent foster care adolescents, as defined in 42 U.S.C. Section 1396d, or who are within reasonable categories of such adolescents who are under twenty-one years of age as specified by the state, are eligible for coverage under 42 U.S.C. Section 1396a (a)(10)(A)(ii)(XVII) without regard to income or assets**]** in foster care under the responsibility of the state of Missouri on the date such persons attain the age of eighteen years, or at any time during the thirty-day period preceding their eighteenth birthday, without regard to income or assets, if such persons:

(a) Are under twenty-six years of age;

(b) Are not eligible for coverage under another mandatory coverage group; and

(c) Were covered by Medicaid while they were in foster care.

2. Rules and regulations to implement this section shall be promulgated in accordance with **[**section 431.064 and**]** chapter 536. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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 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 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 MO HealthNet benefits without fee for an additional six months. The MO HealthNet division may provide by rule and as authorized by annual appropriation the scope of MO HealthNet coverage to be granted to such families.

4. When any individual has been determined to be eligible for 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 MO HealthNet waiver amendment to the Section 1115 demonstration waiver or for any additional MO HealthNet waivers necessary not to exceed one million dollars in additional costs to the state, unless subject to appropriation or directed by statute, 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) unless such waiver application is approved by the oversight committee created in section 208.955. 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, unless the request for such a waiver is made subject to appropriation or directed by statute.

6. Notwithstanding any other provision of law to the contrary, in any given fiscal year, any persons made eligible for 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. MO HealthNet payments 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 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 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 MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the 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 MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the 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 participants, except to persons with more than five hundred thousand dollars equity in their home or except 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 MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The 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 participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he is visiting a friend or relative;

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

(7) Drugs and medicines when prescribed by a licensed

physician, dentist, [or] podiatrist, or an advanced practice registered nurse; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, [or] podiatrist, or an advanced practice registered nurse 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 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 participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of

the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if her or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(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. 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, 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 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 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**]** an advanced practice registered nurse with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, and regulations promulgated thereunder;

(18) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that

the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

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

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

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

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

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

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

(19) Prescribed medically necessary durable medical

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

(20) Hospice care. As used in this subdivision, 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);

(21) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(22) Prescribed medically necessary optometric services.

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

(23) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

(24) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding

needed to complete the four-year plan developed under this subdivision.

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

(1) Dental services;

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

(3) Optometric services as defined in section 336.010;

(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 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 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, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost

until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the 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, and a generic drug is substituted for a name-brand drug, the 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 participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the

provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the Missouri 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.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

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

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section

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

7. 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 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.

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

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the 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).

10. The MO HealthNet division, may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178 shall not be considered as income for purposes of determining

eligibility under this section.

208.240. The MO HealthNet division within the department of social services may implement a statewide dental delivery system to ensure participation of and access to providers in all areas of the state. The MO HealthNet division may administer the system or may seek a third party experienced in the administration of dental benefits to administer the program under the supervision of the division.

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

(1) **[**Review the recommendations regarding services and**]** Process, review and approve or deny the referral within fifteen business days;

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

(3) Arrange**]** For approved referrals, arrange for the provision of services by **[**an in-home**]** a home- and community-based provider;

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

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

(6)] (3) Notify the referring entity or individual within five business days of receiving the referral if [additional information] a different physical address is required to [process the referral; and

(7) Inform the provider and contact the individual when information is insufficient or the proposed care plan requires additional evaluation by state staff that is not obtained from the referring entity to schedule an in-home assessment to be conducted by the state staff within thirty days] schedule the assessment. The referring entity has five days to provide a current physical address if requested by the department. If a different physical address is needed, the fifteen-day limit included in subdivision (1) of this subsection is suspended until the information is received by the department;

(4) Inform the applicant of:

(a) The full range of available MO HealthNet home- and community-based services, including, but not limited to, adult day care services, home-delivered meals, and the benefits of self-direction and agency model services;

(b) The choice of home- and community-based service providers in the applicant's area, and that some providers conduct their own assessments, but that choosing a provider who

does not conduct assessments will not delay delivery of services; and

(c) The option to choose more than one home- and community-based service provider to deliver or facilitate the services the applicant is qualified to receive;

(5) Prioritize the referrals received, giving the highest priority to referrals for high-risk individuals, followed by individuals who are alleged to be victims of abuse or neglect as a result of an investigation initiated from the elder abuse and neglect hotline, and then followed by individuals who have not selected a provider or who have selected a provider that does not conduct assessments; and

(6) Notify the referring entity and the applicant within ten business days of receiving the referral if it has not scheduled the assessment.

2. If the department of health and senior services [may contract for initial home- and community-based assessments, including a care plan, through an independent third-party assessor. The contract shall include a requirement that:

(1) Within fifteen days of receipt of a referral for service, the contractor shall have made a face-to-face assessment of care need and developed a plan of care; and

(2) The contractor notify the referring entity within five days of receipt of referral if additional information is needed to process the referral.

The contract shall also include the same requirements for such assessments as of January 1, 2010, related to timeliness of assessments and the beginning of service. The contract shall be

bid under chapter 34 and shall not be a risk-based contract**]** has not complied with subdivision (1) of subsection 1 of this section, a provider has the option of completing an assessment and care plan recommendation. At such time that the department approves or modifies the assessment and care plan, the care plan shall become effective; such approval or modification shall occur within five business days after receipt of the assessment and care plan from the provider. If such approval, modification, or denial by the department does not occur within five business days, the provider's care plan shall be approved and payment shall begin to the provider based on the assessment and care plan recommendation submitted by the provider.

3. **[**The two nurse visits authorized by subsection 16 of section 660.300 shall continue to be performed by home- and community-based providers for including, but not limited to, reassessment and level of care recommendations. These reassessments and care plan changes shall be reviewed and approved by the independent third-party assessor. In the event of dispute over the level of care required, the third-party assessor shall conduct a face-to-face review with the client in question.

4. The provisions of this section shall expire August 28, 2013**]** At such time that the department approves or modifies the assessment and care plan, the latest approved care plan shall become effective. If the department assessment determines the client does not meet the level of care, the state shall not be responsible for the cost of services claimed prior to the department's written notification to the provider of such denial.

4. The department shall implement subsections 2 and 3 of this section unless the Centers for Medicare and Medicaid Services disapproves any necessary state plan amendments or waivers to implement the provisions in subsections 2 and 3 of this section allowing providers to perform assessments.

5. The department's auditing of home- and community-based service providers shall include a review of the client plan of care and provider assessments, and choice and communication of home- and community-based service provider service options to individuals seeking MO HealthNet services. Such auditing shall be conducted utilizing a statistically valid sample. The department shall also make publicly available a review of its process for informing participants of service options within MO HealthNet home- and community-based service provider services and information on referrals.

6. For purposes of this section:

(1) "Assessment" means a face-to-face determination that a MO HealthNet participant is eligible for home- and community-based services and:

(a) Is conducted by an assessor trained to perform home- and community-based care assessments;

(b) Uses forms provided by the department;

(c) Includes unbiased descriptions of each available service within home- and community-based services with a clear person-centered explanation of the benefits of each home- and community-based service, whether the applicant qualifies for more than one service and ability to choose more than one provider to deliver or facilitate services; and

(d) Informs the applicant, either by the department or the provider conducting the assessment, that choosing a provider or multiple providers that do not conduct their own assessments will in no way affect the quality of service or the timeliness of the applicant's assessment and authorization process;

(2) A "properly completed referral" shall contain basic information adequate for the department to contact the client or person needing service. At a minimum, the referral shall contain:

(a) The stated need for MO HealthNet home- and community-based services;

(b) The name, date of birth, and Social Security number of the client or person needing service, or the client's or person's MO HealthNet number; and

(c) The current physical address and phone number of the client or person needing services.

Additional information which may assist the department including contact information of a responsible party shall also be submitted.

7. The department shall:

(1) Develop an automated electronic assessment care plan tool to be used by providers; and

(2) Make recommendations to the general assembly by January 1, 2014, for the implementation of the automated electronic assessment care plan tool.

8. No later than December 31, 2014, the department of health and senior services shall submit a report to the general

assembly that reviews the following:

(1) How well the department is doing on meeting the fifteen-day requirement;

(2) The process the department used to approve the assessors;

(3) Financial data on the cost of the program prior to and after enactment of this section;

(4) Any audit information available on assessments performed outside the department; and

(5) The department's staffing policies implemented to meet the fifteen-day assessment requirement.

208.990. 1. Notwithstanding any other provisions of law to the contrary, to be eligible for MO HealthNet coverage individuals shall meet the eligibility criteria set forth in 42 CFR 435, including but not limited to the requirements that:

(1) The individual is a resident of the state of Missouri;

(2) The individual has a valid Social Security number;

(3) The individual is a citizen of the United States or a qualified alien as described in Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. Section 1641, who has provided satisfactory documentary evidence of qualified alien status which has been verified with the Department of Homeland Security under a declaration required by Section 1137(d) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that the applicant or beneficiary is an alien in a satisfactory immigration status; and

(4) An individual claiming eligibility as a pregnant woman shall verify pregnancy.

2. Notwithstanding any other provisions of law to the contrary, effective January 1, 2014, the family support division shall conduct an annual redetermination of all MO HealthNet participants' eligibility as provided in 42 CFR 435.916. The department may contract with an administrative service organization to conduct the annual redeterminations if it is cost effective.

3. The department, or family support division, shall conduct electronic searches to redetermine eligibility on the basis of income, residency, citizenship, identity and other criteria as described in 42 CFR 435.916 upon availability of federal, state, and commercially available electronic data sources. The department, or family support division, may enter into a contract with a vendor to perform the electronic search of eligibility information not disclosed during the application process and obtain an applicable case management system. The department shall retain final authority over eligibility determinations made during the redetermination process.

4. Notwithstanding any other provisions of law to the contrary, applications for MO HealthNet benefits shall be submitted in accordance with the requirements of 42 CFR 435.907 and other applicable federal law. The individual shall provide all required information and documentation necessary to make an eligibility determination, resolve discrepancies found during the redetermination process, or for a purpose directly connected to the administration of the medical assistance program.

5. Notwithstanding any other provisions of law to the contrary, to be eligible for MO HealthNet coverage under section

208.995, individuals shall meet the eligibility requirements set forth in subsection 1 of this section and all other eligibility criteria set forth in 42 CFR 435 and 457, including, but not limited to, the requirements that:

(1) The department of social services shall determine the individual's financial eligibility based on projected annual household income and family size for the remainder of the current calendar year;

(2) The department of social services shall determine household income for the purpose of determining the modified adjusted gross income by including all available cash support provided by the person claiming such individual as a dependent for tax purposes;

(3) The department of social services shall determine a pregnant woman's household size by counting the pregnant woman plus the number of children she is expected to deliver;

(4) CHIP-eligible children shall be uninsured, shall not have access to affordable insurance, and their parent shall pay the required premium;

(5) An individual claiming eligibility as an uninsured woman shall be uninsured.

208.995. 1. For purposes of this section and section 208.990, the following terms mean:

(1) "Child" or "children", a person or persons who are under nineteen years of age;

(2) "CHIP-eligible children", children who meet the eligibility standards for Missouri's children's health insurance program as provided in sections 208.631 to 208.658, including

paying the premiums required under sections 208.631 to 208.658;

(3) "Department", the Missouri department of social services, or a division or unit within the department as designated by the department's director;

(4) "MAGI", the individual's modified adjusted gross income as defined in Section 36B(d)(2) of the Internal Revenue Code of 1986, as amended, and:

(a) Any foreign earned income or housing costs;

(b) Tax-exempt interest received or accrued by the individual; and

(c) Tax-exempt Social Security income;

(5) "MAGI equivalent net income standard", an income eligibility threshold based on modified adjusted gross income that is not less than the income eligibility levels that were in effect prior to the enactment of Public Law 111-148 and Public Law 111-152.

2. (1) Effective January 1, 2014, notwithstanding any other provision of law to the contrary, the following individuals shall be eligible for MO HealthNet coverage as provided in this section:

(a) Individuals covered by MO HealthNet for families as provided in section 208.145;

(b) Individuals covered by transitional MO HealthNet as provided in 42 U.S.C. Section 1396r-6;

(c) Individuals covered by extended MO HealthNet for families on child support closings as provided in 42 U.S.C. Section 1396r-6;

(d) Pregnant women as provided in subdivisions (10), (11),

and (12) of subsection 1 of section 208.151;

(e) Children under one year of age as provided in subdivision (12) of subsection 1 of section 208.151;

(f) Children under six years of age as provided in subdivision (13) of subsection 1 of section 208.151;

(g) Children under nineteen years of age as provided in subdivision (14) of subsection 1 of section 208.151;

(h) CHIP-eligible children; and

(i) Uninsured women as provided in section 208.659.

(2) Effective January 1, 2014, the department shall determine eligibility for individuals eligible for MO HealthNet under subdivision (1) of this subsection based on the following income eligibility standards, unless and until they are changed:

(a) For individuals listed in paragraphs (a), (b), and (c) of subdivision (1) of this subsection, the department shall apply the July 16, 1996, Aid to Families with Dependent Children (AFDC) income standard as converted to the MAGI equivalent net income standard;

(b) For individuals listed in paragraphs (f) and (g) of subdivision (1) of this subsection, the department shall apply one hundred thirty-three percent of the federal poverty level converted to the MAGI equivalent net income standard;

(c) For individuals listed in paragraph (h) of subdivision (1) of this subsection, the department shall convert the income eligibility standard set forth in section 208.633 to the MAGI equivalent net income standard;

(d) For individuals listed in paragraphs (d), (e), and (i) of subdivision (1) of this subsection, the department shall apply

one hundred eighty-five percent of the federal poverty level converted to the MAGI equivalent net income standard;

(3) Individuals eligible for MO HealthNet under subdivision (1) of this subsection shall receive all applicable benefits under section 208.152.

3. The department or appropriate divisions of the department shall promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as the term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2013, shall be invalid and void.

4. The department shall submit such state plan amendments and waivers to the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services as the department determines are necessary to implement the provisions of this section.

660.315. 1. After an investigation and a determination has been made to place a person's name on the employee disqualification list, that person shall be notified in writing mailed to his or her last known address that:

(1) An allegation has been made against the person, the

substance of the allegation and that an investigation has been conducted which tends to substantiate the allegation;

(2) The person's name will be included in the employee disqualification list of the department;

(3) The consequences of being so listed including the length of time to be listed; and

(4) The person's rights and the procedure to challenge the allegation.

2. If no reply has been received within thirty days of mailing the notice, the department may include the name of such person on its list. The length of time the person's name shall appear on the employee disqualification list shall be determined by the director or the director's designee, based upon the criteria contained in subsection 9 of this section.

3. If the person so notified wishes to challenge the allegation, such person may file an application for a hearing with the department. The department shall grant the application within thirty days after receipt by the department and set the matter for hearing, or the department shall notify the applicant that, after review, the allegation has been held to be unfounded and the applicant's name will not be listed.

4. If a person's name is included on the employee disqualification list without the department providing notice as required under subsection 1 of this section, such person may file a request with the department for removal of the name or for a hearing. Within thirty days after receipt of the request, the department shall either remove the name from the list or grant a hearing and set a date therefor.

5. Any hearing shall be conducted in the county of the person's residence by the director of the department or the director's designee. The provisions of chapter 536 for a contested case except those provisions or amendments which are in conflict with this section shall apply to and govern the proceedings contained in this section and the rights and duties of the parties involved. The person appealing such an action shall be entitled to present evidence, pursuant to the provisions of chapter 536, relevant to the allegations.

6. Upon the record made at the hearing, the director of the department or the director's designee shall determine all questions presented and shall determine whether the person shall be listed on the employee disqualification list. The director of the department or the director's designee shall clearly state the reasons for his or her decision and shall include a statement of findings of fact and conclusions of law pertinent to the questions in issue.

7. A person aggrieved by the decision following the hearing shall be informed of his or her right to seek judicial review as provided under chapter 536. If the person fails to appeal the director's findings, those findings shall constitute a final determination that the person shall be placed on the employee disqualification list.

8. A decision by the director shall be inadmissible in any civil action brought against a facility or the in-home services provider agency and arising out of the facts and circumstances which brought about the employment disqualification proceeding, unless the civil action is brought against the facility or the

in-home services provider agency by the department of health and senior services or one of its divisions.

9. The length of time the person's name shall appear on the employee disqualification list shall be determined by the director of the department of health and senior services or the director's designee, based upon the following:

(1) Whether the person acted recklessly or knowingly, as defined in chapter 562;

(2) The degree of the physical, sexual, or emotional injury or harm; or the degree of the imminent danger to the health, safety or welfare of a resident or in-home services client;

(3) The degree of misappropriation of the property or funds, or falsification of any documents for service delivery of an in-home services client;

(4) Whether the person has previously been listed on the employee disqualification list;

(5) Any mitigating circumstances;

(6) Any aggravating circumstances; and

(7) Whether alternative sanctions resulting in conditions of continued employment are appropriate in lieu of placing a person's name on the employee disqualification list. Such conditions of employment may include, but are not limited to, additional training and employee counseling. Conditional employment shall terminate upon the expiration of the designated length of time and the person's submitting documentation which fulfills the department of health and senior services' requirements.

10. The removal of any person's name from the list under

this section shall not prevent the director from keeping records of all acts finally determined to have occurred under this section.

11. The department shall provide the list maintained pursuant to this section to other state departments upon request and to any person, corporation, organization, or association who:

(1) Is licensed as an operator under chapter 198;

(2) Provides in-home services under contract with the department;

(3) Employs nurses and nursing assistants for temporary or intermittent placement in health care facilities;

(4) Is approved by the department to issue certificates for nursing assistants training;

(5) Is an entity licensed under chapter 197;

(6) Is a recognized school of nursing, medicine, or other health profession for the purpose of determining whether students scheduled to participate in clinical rotations with entities described in subdivision (1), (2), or (5) of this subsection are included in the employee disqualification list; or

(7) Is a consumer reporting agency regulated by the federal Fair Credit Reporting Act that conducts employee background checks on behalf of entities listed in subdivisions (1), (2), (5), or (6) of this subsection. Such a consumer reporting agency shall conduct the employee disqualification list check only upon the initiative or request of an entity described in subdivisions (1), (2), (5), or (6) of this subsection when the entity is fulfilling its duties required under this section. The information shall be disclosed only to the requesting entity.

The department shall inform any person listed above who inquires of the department whether or not a particular name is on the list. The department may require that the request be made in writing. No person, corporation, organization, or association who is entitled to access the employee disqualification list may disclose the information to any person, corporation, organization, or association who is not entitled to access the list. Any person, corporation, organization, or association who is entitled to access the employee disqualification list who discloses the information to any person, corporation, organization, or association who is not entitled to access the list shall be guilty of an infraction.

12. No person, corporation, organization, or association who received the employee disqualification list under subdivisions (1) to (7) of subsection 11 of this section shall knowingly employ any person who is on the employee disqualification list. Any person, corporation, organization, or association who received the employee disqualification list under subdivisions (1) to (7) of subsection 11 of this section, or any person responsible for providing health care service, who declines to employ or terminates a person whose name is listed in this section shall be immune from suit by that person or anyone else acting for or in behalf of that person for the failure to employ or for the termination of the person whose name is listed on the employee disqualification list.

13. Any employer **[**who is**]** <u>or vendor as defined in sections 197.250, 197.400, 198.006, 208.900, or 660.250</u> required to **[**discharge an employee because the employee was placed on a

disqualification list maintained by the department of health and senior services after the date of hire**]** deny employment to an applicant or to discharge an employee, provisional or otherwise, as a result of information obtained through any portion of the background screening and employment eligibility determination process under section 210.903, or subsequent, periodic screenings, shall not be liable in any action brought by the applicant or employee relating to discharge where the employer is required by law to terminate the employee, provisional or otherwise, and shall not be charged for unemployment insurance benefits based on wages paid to the employee for work prior to the date of discharge, pursuant to section 288.100**[.]**, if the employer terminated the employee because the employee:

(1) Has been found guilty, pled guilty or nolo contendere in this state or any other state of a crime as listed in subsection 6 of section 660.317;

(2) Was placed on the employee disqualification list under this section after the date of hire;

(3) Was placed on the employee disqualification registry maintained by the department of mental health after the date of hire;

(4) Has a disqualifying finding under this section, section 660.317, or is on any of the background check lists in the family care safety registry under sections 210.900 to 210.936; or

(5) Was denied a good cause waiver as provided for in subsection 10 of section 660.317.

14. Any person who has been listed on the employee disqualification list may request that the director remove his or

her name from the employee disqualification list. The request shall be written and may not be made more than once every twelve months. The request will be granted by the director upon a clear showing, by written submission only, that the person will not commit additional acts of abuse, neglect, misappropriation of the property or funds, or the falsification of any documents of service delivery to an in-home services client. The director may make conditional the removal of a person's name from the list on any terms that the director deems appropriate, and failure to comply with such terms may result in the person's name being relisted. The director's determination of whether to remove the person's name from the list is not subject to appeal.

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David Sater

Donna Lichtenegger