

SECOND REGULAR SESSION  
[PERFECTED]  
HOUSE SUBSTITUTE FOR  
HOUSE COMMITTEE SUBSTITUTE FOR  
**HOUSE BILL NO. 1566**  
**92ND GENERAL ASSEMBLY**

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Taken up for Perfection March 17, 2004. House Substitute for House Committee Substitute for House Bill No. 1566 ordered Perfected and printed, as amended.

STEPHEN S. DAVIS, Chief Clerk

4719L.07P

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**AN ACT**

To repeal sections 208.145, 208.146, 208.151, 208.152, 208.631, 208.636, and 208.640, RSMo, and to enact in lieu thereof nine new sections relating to medical assistance cost containment within the Medicaid program.

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

Section A. Sections 208.145, 208.146, 208.151, 208.152, 208.631, 208.636, and  
2 208.640, RSMo, are repealed and nine new sections enacted in lieu thereof, to be known as  
3 sections 208.145, 208.146, 208.147, 208.151, 208.152, 208.212, 208.631, 208.636, and 208.640,  
4 to read as follows:

208.145. **1.** For the purposes of the application of section 208.151, individuals shall be  
2 deemed to be recipients of aid to families with dependent children and individuals shall be  
3 deemed eligible for such assistance if:

4 (1) The individual meets eligibility requirements which are no more restrictive than the  
5 July 16, 1996, eligibility requirements for aid to families with dependent children, as established  
6 by the division of family services; or

7 (2) Each dependent child, and each relative with whom such a child is living including  
8 the spouse of such relative as described in 42 U.S.C. 606(b), as in effect on July 16, 1996, who  
9 ceases to meet the eligibility criteria set forth in subdivision (1) of this section as a result of the  
10 collection or increased collection of child or spousal support under part IV-D of the Social

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

11 Security Act, 42 U.S.C. 651 et seq., and who has received such aid in at least three of the six  
12 months immediately preceding the month in which ineligibility begins, shall be deemed eligible  
13 for an additional four calendar months beginning with the month in which such ineligibility  
14 begins.

15 **2. In addition to any other eligibility requirements, any person listed in subsection**  
16 **1 of this section shall not be eligible for benefits if the parent and child or children in the**  
17 **home owns or possesses resources that exceed one thousand dollars; provided that, if such**  
18 **person is married and living with a spouse, the parents and child or children may own**  
19 **resources not to exceed two thousand dollars. The following assets shall be excluded:**

20 **(1) The home occupied by the claimant as the claimant's principal place of**  
21 **residence. For town or city property, lots on which there is no dwelling and which adjoin**  
22 **the residence are considered a part of the home, regardless of the number of lots so long**  
23 **as they are in the same city block. For rural property, the acreage on which the home is**  
24 **located plus any adjoining acreage shall be considered part of the home. Property shall be**  
25 **considered as adjoining even though a road may separate two tracts;**

26 **(2) One automobile. Additional automobiles shall be excluded if providing**  
27 **transportation for any of the following purposes: employment, school or church**  
28 **attendance, or obtaining medical care;**

29 **(3) Real or personal property that produces annual income consistent with its fair**  
30 **market value if it is being used directly by the claimant in the course of the claimant's**  
31 **business or employment;**

32 **(4) Household furnishings, household goods, and personal effects used by the**  
33 **claimant;**

34 **(5) Wedding and engagement rings;**

35 **(6) Jewelry, other than wedding and engagement rings, that is of limited value;**

36 **(7) Amounts placed in an irrevocable prearranged funeral or burial contract under**  
37 **subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section**  
38 **436.053, RSMo;**

39 **(8) Up to one thousand five hundred dollars cash surrender value per person of any**  
40 **life insurance policy, or prearranged funeral or burial contract, or any two or more**  
41 **policies or contracts, or any combination of policies or contracts. The value of an**  
42 **irrevocable prearranged funeral or burial contract shall be counted toward the one**  
43 **thousand five hundred dollar exclusion before the exclusion is applied to other life**  
44 **insurance policies or prearranged funeral or burial contracts;**

45           **(9) One burial lot per person. For purposes of this section, "burial lot" means any**  
46 **burial space as defined in section 214.270, RSMo, and any memorial, monument, marker,**  
47 **tombstone, or letter marking a burial space;**

48           **(10) Payments made from the Agent Orange Settlement Fund or any other fund**  
49 **established under the settlement in the *In Re Agent Orange* product liability litigation,**  
50 **M.D.L. No. 381 (E.D.N.Y.) shall not be considered income or resources in determining**  
51 **eligibility for or the amount of benefits under any state or state-assisted program;**

52           **(11) Any proceeds from involuntary conversion of real property into personal**  
53 **property, such as forced transfer under condemnation, eminent domain, and fire, flood,**  
54 **or other act of God, received by a recipient while eligible to receive public assistance**  
55 **benefits under existing laws shall be considered real property and excluded from resources**  
56 **for a period of one year from the time of their receipt. For purposes of this subdivision,**  
57 **"receipt" means actual receipt of the proceeds or the payment into court of the proceeds;**  
58 **except that in condemnation cases when the initial exception to the commissioner's award**  
59 **is filed by the condemning authority, "receipt" means receipt of an award under a final**  
60 **judgment;**

61           **(12) Relocation payments received by a claimant through the Uniform Relocation**  
62 **Assistance Act of 1970. Section 216 of Public Law 91-646 states that payments to help a**  
63 **recipient resettle when property purchased by the state transportation department or**  
64 **property purchased under the Housing Act causes an assistance recipient to relocate shall**  
65 **not be considered in determining eligibility for public assistance;**

66           **(13) Settlement payments made from the Ricky Ray Hemophilia Relief Fund, or**  
67 **paid as a result of a class action settlement in the case of *Susan Walker v. Bayer***  
68 ***Corporation*;**

69           **(14) Radiation Exposure Compensation Act payments authorized by Public Law**  
70 **101-426, enacted October 15, 1990;**

71           **(15) Payments received by any member of the Passamaquoddy Indian Tribe, the**  
72 **Penobscot Nation, or the Houlton Band of Malisett Indians under the Maine Indian Claims**  
73 **Act of 1980, Public Law 96-420;**

74           **(16) Payments received by any member of the Aroostook Band of Micmacs under**  
75 **the Aroostook Band of Micmacs Settlement Act, Public Law 102-171;**

76           **(17) For a period not to exceed six months, such real property that the family is**  
77 **making a good faith effort to sell;**

78           **(18) Family development accounts established pursuant to sections 208.750 to**  
79 **208.775, RSMo;**

80           **(19) Earned income tax credit and child tax credit payments in the month of receipt**  
81 **and the month immediately following receipt;**

82           **(20) In addition to the exclusions set forth above, all exclusions set forth in any**  
83 **federal law that is applicable to Title XIX, Public Law 89-97, 1965 amendments to the**  
84 **federal Social Security Act (42 U.S.C. section 301 et seq.) as amended shall also apply.**

208.146. 1. Pursuant to the federal Ticket to Work and Work Incentives Improvement  
2 Act of 1999 (TWWIA) (Public Law 106-170), the medical assistance provided for in section  
3 208.151 may be paid for a person who is employed and who:

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

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

8           (3) Has a gross income of two hundred fifty percent or less of the federal poverty  
9 guidelines. For purposes of this subdivision, "income" does not include any income of the  
10 person's spouse up to one hundred thousand dollars or children. Individuals with incomes in  
11 excess of one hundred fifty percent of the federal poverty level shall pay a premium for  
12 participation in accordance with subsection 5 of this section.

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

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

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

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

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

21 or

22           (5) PASS plans.

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

31 shall not be considered an asset for purposes of determining and maintaining eligibility pursuant  
32 to section 208.151 until such person reaches the age of sixty-five.

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

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

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

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

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

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

53 6. If the department elects to pay employer-sponsored insurance pursuant to subsection  
54 4 of this section then the medical assistance established by this section shall be provided to an  
55 eligible person as a secondary or supplemental policy to any employer-sponsored benefits which  
56 may be available to such person.

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

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

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

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

68 **11. Notwithstanding any other provision of law to the contrary, in any given fiscal**  
69 **year, any persons made eligible for medical assistance benefits under subsections 1 to 6 of**  
70 **this section shall only be eligible if annual appropriations are made for such eligibility.**  
71 **This subsection shall not apply to classes of individuals listed in 42 U.S.C. Section**  
72 **1396a(a)(10)(A)(i).**

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

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

6 3. (1) The department shall require recipients to provide documentation for income  
7 verification for purposes of the eligibility review described in subsection 1 of this section.  
8 Such documentation may include, but not be limited to:

- 9 (a) Current wage stubs;
- 10 (b) A current W-2 form;
- 11 (c) Statements from the recipient's employer; and
- 12 (d) A wage match with the division of employment security.

13 (2) The family support division may also verify information through inquiry into  
14 the personal property and driver's licensing systems of the department of revenue, or  
15 through other data matches.

16 4. The department shall by rule establish procedures that require applicants or  
17 recipients to disclose at the time of application or the annual eligibility review whether  
18 their employer offers employer-sponsored health insurance that they are eligible to receive,  
19 whether the applicant or recipient participates in the employer-sponsored health insurance  
20 program, and to disclose the applicant's or recipient's reason for not participating in the  
21 employer-sponsored plan, if applicable. If the applicant or recipient is unemployed at the  
22 time of application or the annual eligibility review, the department shall also establish by  
23 rule procedures that require the applicant or recipient to disclose whether they have sought  
24 employment.

25 5. Notwithstanding the cost-sharing provisions in subsection 3 of section 208.152,  
26 RSMo, the department shall promulgate rules that require all recipients of medical  
27 assistance to participate in cost-sharing activities, subject to the provisions of 42 U.S.C.  
28 Section 1396o. The provisions of this subsection shall not apply to subdivision 9 of

29 subsection 1 of section 208.152, RSMo, and sections 208.631 to 208.657, RSMo. The  
30 provisions of this subsection shall not apply to home health or in-home services.

31 6. For purposes of determining the copayment amount described in subsection 5  
32 of this section, the following guidelines shall apply:

33 (1) For services in which the state's payment for the service is ten dollars or less,  
34 the maximum copayment shall be fifty cents;

35 (2) For services in which the state's payment for the service is between ten dollars  
36 one cent and twenty-five dollars, the maximum copayment shall be one dollar;

37 (3) For services in which the state's payment for the service is between twenty-five  
38 dollars one cent and fifty dollars, the maximum copayment shall be two dollars; and

39 (4) For services in which the state's payment for the service is more than fifty  
40 dollars, the maximum copayment shall be three dollars.

41 7. Providers shall make a reasonable effort to collect the copayments set forth in  
42 subsections 5 and 6 of this section from the recipient at the time the service is provided.  
43 Any full or partial copayment made by the recipient shall be entered on the provider's  
44 submitted claim and deducted by the division of medical services from the usual payment  
45 to the provider. The payment made by the division of medical services to the provider shall  
46 not be decreased by the recipient's failure to pay the copayment.

47 8. When the division of medical services receives a claim from a provider for  
48 nonpayment of a mandatory copayment, the division shall send a notice to the recipient.  
49 Such notice shall:

50 (1) Request the recipient to reimburse the division of medical services for the  
51 mandatory copayment made on the recipient's behalf; and

52 (2) Request information from the recipient to determine whether the mandatory  
53 copayment was not made because of a change in the financial situation of the recipient.

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

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

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

9 (3) All recipients of blind pension benefits;

10 (4) All persons who would be determined to be eligible for old age assistance benefits,  
11 permanent and total disability benefits, or aid to the blind benefits under the eligibility standards

12 in effect December 31, 1973, or less restrictive standards as established by rule of the division  
13 of family services, who are sixty-five years of age or over and are patients in state institutions  
14 for mental diseases or tuberculosis;

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

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

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

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

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

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

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

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

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

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



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

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

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

61 (b) Children who have attained one year of age but have not attained six years of age  
62 with family income greater than one hundred thirty-three percent of the federal poverty guideline  
63 for the applicable family size; and

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

67

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

83 the requirement of federal law and regulations. Coverage under this subdivision shall be subject  
84 to appropriation to provide services approved under the provisions of this subdivision;

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

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

94 (18) A child born to a woman eligible for and receiving medical assistance under this  
95 section on the date of the child's birth shall be deemed to have applied for medical assistance and  
96 to have been found eligible for such assistance under such plan on the date of such birth and to  
97 remain eligible for such assistance for a period of time determined in accordance with applicable  
98 federal and state law and regulations so long as the child is a member of the woman's household  
99 and either the woman remains eligible for such assistance or for children born on or after January  
100 1, 1991, the woman would remain eligible for such assistance if she were still pregnant. Upon  
101 notification of such child's birth, the division of family services shall assign a medical assistance  
102 eligibility identification number to the child so that claims may be submitted and paid under such  
103 child's identification number;

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

115 (20) Subject to appropriations necessary to recruit and train such staff, the division of  
116 family services shall provide one or more full-time, permanent case workers to process  
117 applications for medical assistance at the site of a health care provider, if the health care provider  
118 requests the placement of such case workers and reimburses the division for the expenses

119 including but not limited to salaries, benefits, travel, training, telephone, supplies, and  
120 equipment, of such case workers. The division may provide a health care provider with a  
121 part-time or temporary case worker at the site of a health care provider if the health care provider  
122 requests the placement of such a case worker and reimburses the division for the expenses,  
123 including but not limited to the salary, benefits, travel, training, telephone, supplies, and  
124 equipment, of such a case worker. The division may seek to employ such case workers who are  
125 otherwise qualified for such positions and who are current or former welfare recipients. The  
126 division may consider training such current or former welfare recipients as case workers for this  
127 program;

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

132 (22) Case management services for pregnant women and young children at risk shall be  
133 a covered service. To the greatest extent possible, and in compliance with federal law and  
134 regulations, the department of health and senior services shall provide case management services  
135 to pregnant women by contract or agreement with the department of social services through local  
136 health departments organized under the provisions of chapter 192, RSMo, or chapter 205, RSMo,  
137 or a city health department operated under a city charter or a combined city-county health  
138 department or other department of health and senior services designees. To the greatest extent  
139 possible the department of social services and the department of health and senior services shall  
140 mutually coordinate all services for pregnant women and children with the crippled children's  
141 program, the prevention of mental retardation program and the prenatal care program  
142 administered by the department of health and senior services. The department of social services  
143 shall by regulation establish the methodology for reimbursement for case management services  
144 provided by the department of health and senior services. For purposes of this section, the term  
145 "case management" shall mean those activities of local public health personnel to identify  
146 prospective Medicaid-eligible high-risk mothers and enroll them in the state's Medicaid program,  
147 refer them to local physicians or local health departments who provide prenatal care under  
148 physician protocol and who participate in the Medicaid program for prenatal care and to ensure  
149 that said high-risk mothers receive support from all private and public programs for which they  
150 are eligible and shall not include involvement in any Medicaid prepaid, case-managed programs;

151 (23) By January 1, 1988, the department of social services and the department of health  
152 and senior services shall study all significant aspects of presumptive eligibility for pregnant  
153 women and submit a joint report on the subject, including projected costs and the time needed  
154 for implementation, to the general assembly. The department of social services, at the direction

155 of the general assembly, may implement presumptive eligibility by regulation promulgated  
156 pursuant to chapter 207, RSMo;

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

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

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

173 (b) Eligibility standards for permanent and total disability benefits shall not be limited  
174 by age;

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

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

183 2. Rules and regulations to implement this section shall be promulgated in accordance  
184 with section 431.064, RSMo, and chapter 536, RSMo. Any rule or portion of a rule, as that term  
185 is defined in section 536.010, RSMo, that is created under the authority delegated in this section  
186 shall become effective only if it complies with and is subject to all of the provisions of chapter  
187 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo,  
188 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter  
189 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are

190 subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed  
191 or adopted after August 28, 2002, shall be invalid and void.

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

209           4. For purposes of Section 1902(1), (10) of Title XIX of the federal Social Security Act,  
210 as amended, any individual who, for the month of August, 1972, was eligible for or was  
211 receiving aid or assistance pursuant to the provisions of Titles I, X, XIV, or Part A of Title IV  
212 of such act and who, for such month, was entitled to monthly insurance benefits under Title II  
213 of such act, shall be deemed to be eligible for such aid or assistance for such month thereafter  
214 prior to October, 1974, if such individual would have been eligible for such aid or assistance for  
215 such month had the increase in monthly insurance benefits under Title II of such act resulting  
216 from enactment of Public Law 92-336 amendments to the federal Social Security Act (42 U.S.C.  
217 301 et seq.), as amended, not been applicable to such individual.

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

223           6. The department of social services may apply to the federal Department of Health and  
224 Human Services for a Medicaid waiver amendment to the Section 1115 demonstration waiver

225 or for any additional Medicaid waivers necessary and desirable to implement the increased  
226 income limit, as authorized in subdivision (25) of subsection 1 of this section.

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

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

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

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

21 (3) Laboratory and X-ray services;

22 (4) Nursing home services for recipients, except to persons in an institution for mental  
23 diseases who are under the age of sixty-five years, when residing in a hospital licensed by the  
24 department of health and senior services or a nursing home licensed by the division of aging or  
25 appropriate licensing authority of other states or government-owned and -operated institutions  
26 which are determined to conform to standards equivalent to licensing requirements in Title XIX,  
27 of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities.  
28 The division of medical services may recognize through its payment methodology for nursing  
29 facilities those nursing facilities which serve a high volume of Medicaid patients. The division

30 of medical services when determining the amount of the benefit payments to be made on behalf  
31 of persons under the age of twenty-one in a nursing facility may consider nursing facilities  
32 furnishing care to persons under the age of twenty-one as a classification separate from other  
33 nursing facilities;

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

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

43 (7) Dental services;

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

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

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

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

59 (12) Home health care services;

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

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

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

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

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

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

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

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



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

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

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

127 (21) Hospice care. As used in this subsection, the term "hospice care" means a  
128 coordinated program of active professional medical attention within a home, outpatient and  
129 inpatient care which treats the terminally ill patient and family as a unit, employing a medically  
130 directed interdisciplinary team. The program provides relief of severe pain or other physical  
131 symptoms and supportive care to meet the special needs arising out of physical, psychological,  
132 spiritual, social and economic stresses which are experienced during the final stages of illness,  
133 and during dying and bereavement and meets the Medicare requirements for participation as a  
134 hospice as are provided in 42 CFR Part 418. Beginning July 1, 1990, the rate of reimbursement  
135 paid by the division of medical services to the hospice provider for room and board furnished

136 by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the  
137 rate of reimbursement which would have been paid for facility services in that nursing home  
138 facility for that patient, in accordance with subsection (c) of section 6408 of P.L. 101-239  
139 (Omnibus Budget Reconciliation Act of 1989);

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

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

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

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

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

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

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

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

170 (c) For each day that nursing home costs are paid on behalf of a recipient pursuant to this  
171 subdivision during any period of six consecutive months such recipient shall, during the same

172 period of six consecutive months, be ineligible for payment of nursing home costs of two  
173 otherwise available temporary leave of absence days provided under subdivision (5) of this  
174 subsection; and

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

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

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

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

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

205 6. Beginning July 1, 1990, reimbursement for services rendered in federally funded  
206 health centers shall be in accordance with the provisions of subsection 6402(c) and section 6404

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

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

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

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

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

225 **10. Notwithstanding any other provision of law to the contrary, in any given fiscal**  
226 **year, any optional benefit provided by the department under subdivisions (1) to (25) of**  
227 **subsection 1 of this section shall only be provided if appropriations are made available for**  
228 **such benefits. An "optional benefit" means a benefit not required to be provided under**  
229 **42 U.S.C. Section 1396a(a)(10)(A) and 42 U.S.C. Section 1396d(a)(1) to (5), (17), and (21).**  
230 **If in any given fiscal year moneys are not appropriated to fund one or more of such**  
231 **optional benefits, such benefits shall not be provided and persons otherwise eligible for**  
232 **such benefits shall no longer be deemed eligible.**

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

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

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

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

10           **2. The department shall establish a thirty-six month look-back period to review any**  
11 **investment in an annuity by an applicant for Medicaid benefits. If an investment in an**  
12 **annuity is determined by the department to have been made in anticipation of obtaining**  
13 **or with an intent to obtain eligibility for Medicaid benefits, the department shall have**  
14 **available all remedies and sanctions permitted under federal and state law regarding such**  
15 **investment. The fact that an investment in an annuity which occurred prior to the effective**  
16 **date of this section does not meet the criteria established in subsection 1 of this section shall**  
17 **not automatically result in a disallowance of such investment.**

18           **3. The department of social services shall promulgate rules to administer the**  
19 **provisions of this section. Any rule or portion of a rule, as that term is defined in section**  
20 **536.010, RSMo, that is created under the authority delegated in this section shall become**  
21 **effective only if it complies with and is subject to all of the provisions of chapter 536,**  
22 **RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are**  
23 **nonseverable and if any of the powers vested with the general assembly pursuant to**  
24 **chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule**  
25 **are subsequently held unconstitutional, then the grant of rulemaking authority and any**  
26 **rule proposed or adopted after August 28, 2004, shall be invalid and void.**

208.631. 1. Notwithstanding any other provision of law to the contrary, the department  
2 of social services shall establish a program to pay for health care for uninsured children.  
3 Coverage pursuant to sections 208.631 to [208.660] **208.657** is subject to **annual** appropriation,  
4 **and if funds are not appropriated for a given fiscal year, individuals otherwise eligible for**  
5 **coverage under sections 208.631 to 208.657 shall no longer be eligible.** The provisions of  
6 sections 208.631 to 208.657 shall be void and of no effect after July 1, 2007.

7           2. For the purposes of sections 208.631 to 208.657, "children" are persons up to nineteen  
8 years of age. "Uninsured children" are persons up to nineteen years of age who are emancipated  
9 and do not have access to affordable employer-subsidized health care insurance or other health  
10 care coverage or persons whose parent or guardian have not had access to affordable  
11 employer-subsidized health care insurance or other health care coverage for their children for six  
12 months prior to application, are residents of the state of Missouri, and have parents or guardians  
13 who meet the requirements in section 208.636. A child who is eligible for medical assistance  
14 as authorized in section 208.151 is not uninsured for the purposes of sections 208.631 to  
15 208.657.

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

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

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

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

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

16 (5) Demonstrate annually that [their total net worth does not exceed two hundred fifty  
17 thousand dollars in total value] **the parent and child or children in the home do not own or**  
18 **possess resources which exceed twenty-five thousand dollars. The following assests shall**  
19 **be excluded:**

20 (1) **The home occupied by the claimant as the claimant's principal place of**  
21 **residence. For town or city property, lots on which there is no dwelling and which adjoin**  
22 **the residence are considered a part of the home, regardless of the number of lots so long**  
23 **as they are in the same city block. For rural property, the acreage on which the home is**  
24 **located plus any adjoining acreage shall be considered part of the home. Property shall be**  
25 **considered as adjoining even though a road may separate two tracts;**

26 (2) **One automobile. Additional automobiles shall be excluded if providing**  
27 **transportation for any of the following purposes: employment, school or church**  
28 **attendance, or obtaining medical care;**

29 (3) **Real or personal property that produces annual income consistent with its fair**  
30 **market value if it is being used directly by the claimant in the course of the claimant's**  
31 **business or employment;**

32 (4) **Household furnishings, household goods, and personal effects used by the**  
33 **claimant;**

34 (5) **Wedding and engagement rings;**

35 (6) **Jewelry, other than wedding and engagement rings, that is of limited value;**

36 (7) **Amounts placed in an irrevocable prearranged funeral or burial contract under**  
37 **subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section**  
38 **436.053, RSMo;**

39 (8) **Up to one thousand five hundred dollars cash surrender value per person of any**  
40 **life insurance policy, or prearranged funeral or burial contract, or any two or more**

41 policies or contracts, or any combination of policies or contracts. The value of an  
42 irrevocable prearranged funeral or burial contract shall be counted toward the one  
43 thousand five hundred dollar exclusion before the exclusion is applied to other life  
44 insurance policies or prearranged funeral or burial contracts;

45 (9) One burial lot per person. For purposes of this section, "burial lot" means any  
46 burial space as defined in section 214.270, RSMo, and any memorial, monument, marker,  
47 tombstone, or letter marking a burial space;

48 (10) Payments made from the Agent Orange Settlement Fund or any other fund  
49 established under the settlement in the *In Re Agent Orange* product liability litigation,  
50 M.D.L. No. 381 (E.D.N.Y.) shall not be considered income or resources in determining  
51 eligibility for or the amount of benefits under any state or state-assisted program;

52 (11) Any proceeds from involuntary conversion of real property into personal  
53 property, such as forced transfer under condemnation, eminent domain, and fire, flood,  
54 or other act of God, received by a recipient while eligible to receive public assistance  
55 benefits under existing laws shall be considered real property and excluded from resources  
56 for a period of one year from the time of their receipt. For purposes of this subdivision,  
57 "receipt" means actual receipt of the proceeds or the payment into court of the proceeds;  
58 except that in condemnation cases when the initial exception to the commissioner's award  
59 is filed by the condemning authority, "receipt" means receipt of an award under a final  
60 judgment;

61 (12) Relocation payments received by a claimant through the Uniform Relocation  
62 Assistance Act of 1970. Section 216 of Public Law 91-646 states that payments to help a  
63 recipient resettle when property purchased by the state transportation department or  
64 property purchased under the Housing Act causes an assistance recipient to relocate shall  
65 not be considered in determining eligibility for public assistance;

66 (13) Settlement payments made from the Ricky Ray Hemophilia Relief Fund, or  
67 paid as a result of a class action settlement in the case of *Susan Walker v. Bayer*  
68 *Corporation*;

69 (14) Radiation Exposure Compensation Act payments authorized by Public Law  
70 101-426, enacted October 15, 1990;

71 (15) Payments received by any member of the Passamaquoddy Indian Tribe, the  
72 Penobscot Nation, or the Houlton Band of Malisett Indians under the Maine Indian Claims  
73 Act of 1980, Public Law 96-420;

74 (16) Payments received by any member of the Aroostook Band of Micmacs under  
75 the Aroostook Band of Micmacs Settlement Act, Public Law 102-171;

76           **(17) For a period not to exceed six months, such real property that the family is**  
77 **making a good faith effort to sell;**

78           **(18) Family development accounts established pursuant to sections 208.750 to**  
79 **208.775, RSMo;**

80           **(19) Earned income tax credit and child tax credit payments in the month of receipt**  
81 **and the month immediately following receipt;**

82           **(20) In addition to the exclusions set forth above, all exclusions set forth in any**  
83 **federal law that is applicable to Title XIX, Public Law 89-97, 1965 amendments to the**  
84 **federal Social Security Act (42 U.S.C. section 301 et seq.) as amended shall also apply.**

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

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