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HOUSE SUBSTITUTE

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 1566

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.

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Section A. Sections 208.145, 208.146, 208.151, 208.152, 208.631, 208.636, and 208.640, RSMo, are repealed and nine new sections enacted in lieu thereof, to be known as sections 208.145, 208.146, 208.147, 208.151, 208.152, 208.212, 208.631, 208.636, and 208.640, to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

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

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

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

(2) Each dependent child, and each relative with whom such a child is living including the spouse of such relative as described in 42 U.S.C. 606(b), as in effect on July 16, 1996, who ceases to meet the eligibility criteria set forth in subdivision (1) of this section as a result of the collection or increased collection of child or spousal support under part IV-D of the Social Security Act, 42 U.S.C. 651 et seq., and who has received such aid in at least three of the six months immediately preceding the month in which ineligibility begins, shall be deemed eligible for an additional four calendar months beginning with the month in which such ineligibility begins.

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

(1) The home occupied by the claimant as the claimant's principal place of residence. For town or city property, lots on which there is no dwelling and which adjoin the residence are considered a part of the home, regardless of the number of lots so long as they are in the same city block. For rural property, the acreage on which the home is located plus any adjoining

acreage shall be considered part of the home. Property shall be considered as adjoining even though a road may separate two tracts;

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

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

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

(5) Wedding and engagement rings;

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

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

(8) Up to one thousand five hundred dollars cash surrender value per person of any life insurance policy, or prearranged funeral or burial contract, or any two or more policies or contracts, or any combination of policies or contracts. The value of an irrevocable prearranged funeral or burial contract shall be counted toward the one thousand five hundred dollar

exclusion before the exclusion is applied to other life insurance policies or prearranged funeral or burial contracts;

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

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

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

(12) Relocation payments received by a claimant through the

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

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

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

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

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

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

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

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

(20) In addition to the exclusions set forth above, all exclusions set forth in any federal law that is applicable to Title XIX, Public Law 89-97, 1965 amendments to the 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 Act of 1999 (TWWIIA) (Public Law 106-170), the medical assistance provided for in section 208.151 may be paid for a person who is employed and who:

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

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

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

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

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

to section 208.010;

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

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

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

(5) PASS plans.

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

4. If an eligible individual's employer offers employer-sponsored health insurance and the department of social

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

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

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

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

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

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

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

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

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

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

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

11. Notwithstanding any other provision of law to the contrary, in any given fiscal year, any persons made eligible for medical assistance benefits under subsections 1 to 6 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).

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

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

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

(a) Current wage stubs;

(b) A current W-2 form;

(c) Statements from the recipient's employer; and

(d) A wage match with the division of employment security.

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

4. The department shall by rule establish procedures that require applicants or recipients to disclose at the time of application or the annual eligibility review whether their

employer offers employer-sponsored health insurance that they are eligible to receive, whether the applicant or recipient participates in the employer-sponsored health insurance program, and to disclose the applicant's or recipient's reason for not participating in the employer-sponsored plan, if applicable. If the applicant or recipient is unemployed at the time of application or the annual eligibility review, the department shall also establish by rule procedures that require the applicant or recipient to disclose whether they have sought employment.

5. Notwithstanding the cost-sharing provisions in section 208.153, the department shall promulgate rules that require all recipients of medical assistance to participate in cost-sharing activities, subject to the provisions of 42 U.S.C. Section 1396o. The provisions of this subsection shall not apply to sections 208.631 to 208.657.

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

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

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

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

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

7. Any copayments for which participants are responsible under subsection 5 of this section shall be a credit against any payments owed by the state for such services; except that if such copayment is not paid by the participant, the state shall pay the amount of the credit to the provider if a claim is made to the division of medical services as outlined in subdivision (3) of subsection 8 of this section.

8. If a mandatory copayment is not paid, the provider may:

(1) Forego the copayment; or

(2) Make arrangements for future payments with the recipient; or

(3) The provider shall make reasonable efforts to collect copayments. After such efforts, the provider may file a claim with the division of medical services certifying that the copayment is uncollected and upon certification may secure payment for the service from the division of medical services. The division may establish by rule the certification procedure.

9. When the division of medical services receives a claim from a provider for nonpayment of a mandatory copayment, the

division shall send a notice to the recipient. Such notice shall:

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

(2) Request information from the recipient to determine whether the mandatory 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 to comply with Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301 et seq.) as amended, the following needy persons shall be eligible to receive medical assistance to the extent and in the manner hereinafter provided:

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

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

(3) All recipients of blind pension benefits;

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

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

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

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

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

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

(9) All persons who were recipients of old age assistance benefits, aid to the permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who continue to meet

the eligibility requirements, except income, for these assistance categories, but who are no longer receiving such benefits because of the implementation of Title XVI of the federal Social Security Act, as amended;

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

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

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

(13) Children who have attained one year of age but have not attained six years of age who are eligible for medical assistance under 6401 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The division of family services 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 division of family services shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency. As necessary to provide Medicaid coverage under this subdivision, the department of social services may revise the state Medicaid plan to extend coverage under 42 U.S.C. 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42 U.S.C. 1396a;

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

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

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

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

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

eligibility for persons under this subdivision. The division of medical services shall define the amount and scope of benefits which are available to individuals under this subdivision in accordance with the requirement of federal law and regulations. Coverage under this subdivision shall be subject to appropriation to provide services approved under the provisions of this subdivision;

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

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

(18) A child born to a woman eligible for and receiving medical assistance under this section on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such

assistance for a period of time determined in accordance with applicable federal and state law and regulations so long as the child is a member of the woman's household and either the woman remains eligible for such assistance or for children born on or after January 1, 1991, the woman would remain eligible for such assistance if she were still pregnant. Upon notification of such child's birth, the division of family services shall assign a medical assistance eligibility identification number to the child so that claims may be submitted and paid under such child's identification number;

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

eligibility under this chapter shall be as simple as practicable;

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

(21) Pregnant women who are eligible for, have applied for and have received medical assistance under subdivision (2), (10), (11) or (12) of this subsection shall continue to be considered eligible for all pregnancy-related and postpartum medical assistance provided under section 208.152 until the end of the

sixty-day period beginning on the last day of their pregnancy;

(22) Case management services for pregnant women and young children at risk shall be a covered service. To the greatest extent possible, and in compliance with federal law and regulations, the department of health and senior services shall provide case management services to pregnant women by contract or agreement with the department of social services through local health departments organized under the provisions of chapter 192, RSMo, or chapter 205, RSMo, or a city health department operated under a city charter or a combined city-county health department or other department of health and senior services designees. To the greatest extent possible the department of social services and the department of health and senior services shall mutually coordinate all services for pregnant women and children with the crippled children's program, the prevention of mental retardation program and the prenatal care program administered by the department of health and senior services. The department of social services shall by regulation establish the methodology for reimbursement for case management services provided by the department of health and senior services. For purposes of this section, the term "case management" shall mean those activities of local public health personnel to identify prospective Medicaid-eligible high-risk mothers and enroll them in the state's Medicaid program, refer them to local physicians or local health departments who provide prenatal care under physician

protocol and who participate in the Medicaid program for prenatal care and to ensure that said high-risk mothers receive support from all private and public programs for which they are eligible and shall not include involvement in any Medicaid prepaid, case-managed programs;

(23) By January 1, 1988, the department of social services and the department of health and senior services shall study all significant aspects of presumptive eligibility for pregnant women and submit a joint report on the subject, including projected costs and the time needed for implementation, to the general assembly. The department of social services, at the direction of the general assembly, may implement presumptive eligibility by regulation promulgated pursuant to chapter 207, RSMo;

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

(25) 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; except that, on or after July 1, 2002, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to eighty percent of the federal poverty level and, as of July 1, 2003, less restrictive income

methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to ninety percent of the federal poverty level and, as of July 1, 2004, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal poverty level. If federal law or regulation authorizes the division of family services to, by rule, exclude the income or resources of a parent or parents of a person under the age of eighteen and such exclusion of income or resources can be limited to such parent or parents, then notwithstanding the provisions of section 208.010:

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

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

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

(27) Persons who have been diagnosed with breast or

cervical cancer and who are eligible for coverage pursuant to 42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. 1396r-1.

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

3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for medical assistance for four calendar months following the

month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for medical assistance for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C. 1396r-6. Each family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. 1396r-6 shall receive medical assistance without fee for an additional six months. The division of medical services may provide by rule the scope of medical assistance coverage to be granted to such families.

4. For purposes of Section 1902(1), (10) of Title XIX of the federal Social Security Act, as amended, any individual who, for the month of August, 1972, was eligible for or was receiving aid or assistance pursuant to the provisions of Titles I, X, XIV, or Part A of Title IV of such act and who, for such month, was entitled to monthly insurance benefits under Title II of such act, shall be deemed to be eligible for such aid or assistance

for such month thereafter prior to October, 1974, if such individual would have been eligible for such aid or assistance for such month had the increase in monthly insurance benefits under Title II of such act resulting from enactment of Public Law 92-336 amendments to the federal Social Security Act (42 U.S.C. 301 et seq.), as amended, not been applicable to such individual.

5. When any individual has been determined to be eligible for medical assistance, such medical assistance will be made available to him 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.

6. The department of social services may apply to the federal Department of Health and Human Services for a Medicaid waiver amendment to the Section 1115 demonstration waiver or for any additional Medicaid waivers necessary and desirable to implement the increased income limit, as authorized in subdivision (25) of subsection 1 of this section.

7. Notwithstanding any other provision of law to the contrary, in any given fiscal year, any persons made eligible for medical assistance benefits under subdivisions (1) to (27) of subsection 1 of this section shall only be eligible if annual appropriations are made for such eligibility. This subsection

shall not apply to classes of individuals listed in 42 U.S.C. Section 1396a(a)(10)(A)(i).

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

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

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth

in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the division of medical services may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the division of medical services not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for recipients, except to persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the division of aging or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX, of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The division of medical services may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of Medicaid patients. The division of medical services when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing

facilities;

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

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

(7) Dental services;

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

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

(10) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments. The department of social services may conduct demonstration projects related to the provision of medically necessary transportation to recipients of medical assistance under this chapter. Such demonstration

projects shall be funded only by appropriations made for the purpose of such demonstration projects. If funds are appropriated for such demonstration projects, the department shall submit to the general assembly a report on the significant aspects and results of such demonstration projects;

(11) 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.**[**53**]** 101-239 and federal regulations promulgated thereunder;

(12) Home health care services;

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

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

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

(16) 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.);

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

(18) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his physician on an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the recipient's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for

any one recipient one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time;

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

(20) Comprehensive day rehabilitation services beginning

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

(21) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. Beginning July 1, 1990, the rate of reimbursement paid by the division of medical services to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of

reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

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

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

(24) Subject to appropriations, the department of social services shall conduct demonstration projects for nonemergency, physician-prescribed transportation for pregnant women who are recipients of medical assistance under this chapter in counties selected by the director of the division of medical services. The funds appropriated pursuant to this subdivision shall be used for the purposes of this subdivision and for no other purpose. The department shall not fund such demonstration projects with revenues received for any other purpose. This subdivision shall not authorize transportation of a pregnant woman in active labor.

The division of medical services shall notify recipients of nonemergency transportation services under this subdivision of such other transportation services which may be appropriate during active labor or other medical emergency;

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

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

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

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

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

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

absence days provided under subdivision (5) of this subsection; and

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

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

3. The division of medical services may require any recipient of medical assistance to pay part of the charge or cost, as defined by rule duly promulgated by the division of medical services, for dental services, drugs and medicines, optometric services, eye glasses, dentures, hearing aids, and other services, to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056,

RSMo, and a generic drug is substituted for a name brand drug, the division of medical services may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all recipients the partial payment that may be required by the division of medical services under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by recipients under this section shall be in addition to, and not in lieu of, any payments made by the state for goods or services described herein.

4. The division of medical services shall have the right to collect medication samples from recipients 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 medical assistance at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. 1396a and federal regulations promulgated thereunder.

6. 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 medical assistance under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. 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 Medicaid program shall not increase payments in excess of the increase that would result from the application of section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a (a)(13)(C).

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

providers.

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

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

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

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

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

2. The department shall establish a thirty-six month look-back period to review any investment in an annuity by an

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

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

208.631. 1. Notwithstanding any other provision of law to the contrary, the department of social services shall establish a

program to pay for health care for uninsured children. Coverage pursuant to sections 208.631 to [208.660] 208.657 is subject to annual appropriation, and if funds are not appropriated for a given fiscal year, individuals otherwise eligible for coverage under sections 208.631 to 208.657 shall no longer be eligible. The provisions of sections 208.631 to 208.657 shall be void and of no effect after July 1, 2007.

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

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

(1) Furnish to the department of social services the uninsured child's Social Security number or numbers, if the

uninsured child has more than one such number;

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

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

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

(5) Demonstrate annually that **[**their total net worth does not exceed two hundred fifty thousand dollars in total value**]** the parent and child or children in the home do not own or possess resources which exceed one thousand dollars; provided that if such person is married and living with a spouse, the parents and child or children may own resources not to exceed two thousand dollars. The following assets shall be excluded:

(1) The home occupied by the claimant as the claimant's principal place of residence. For town or city property, lots on which there is no dwelling and which adjoin the residence are

considered a part of the home, regardless of the number of lots so long as they are in the same city block. For rural property, the acreage on which the home is located plus any adjoining acreage shall be considered part of the home. Property shall be considered as adjoining even though a road may separate two tracts;

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

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

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

(5) Wedding and engagement rings;

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

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

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

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

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

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

(11) Any proceeds from involuntary conversion of real property into personal property, such as forced transfer under condemnation, eminent domain, and fire, flood, or other act of God, received by a recipient while eligible to receive public assistance benefits under existing laws shall be considered real property and excluded from resources for a period of one year from the time of their receipt. For purposes of this subdivision, "receipt" means actual receipt of the proceeds or the payment into court of the proceeds; except that in condemnation cases when the initial exception to the

commissioner's award is filed by the condemning authority, "receipt" means receipt of an award under a final judgment;

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

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

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

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

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

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

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

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

(20) In addition to the exclusions set forth above, all exclusions set forth in any federal law that is applicable to Title XIX, Public Law 89-97, 1965 amendments to the 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 between one hundred eighty-six and two hundred twenty- five percent of the federal poverty level are responsible for a five-dollar co-payment.

2.**]** Parents and guardians of uninsured children with incomes between **[**two hundred twenty-six**]** one hundred fifty-one and three hundred percent of the federal poverty level who do not have access to affordable employer-sponsored health care insurance or other affordable health care coverage may obtain coverage pursuant to this subsection. For the purposes of sections 208.631 to 208.657, "affordable employer-sponsored health care insurance or other affordable health care coverage" refers to health insurance requiring a monthly premium less than or equal to one hundred thirty-three percent of the monthly average premium required in the state's current Missouri consolidated health care plan. The parents and guardians of eligible uninsured children pursuant to this subsection are

responsible for co-payments equal to the average co-payments required in the current Missouri consolidated health care plan rounded to the nearest dollar, and a monthly premium equal to the average premium required for the Missouri consolidated health care plan; provided that the total aggregate cost sharing for a family covered by these sections shall not exceed five percent of such family's income for the years involved. No co-payments or other cost sharing is permitted with respect to benefits for well-baby and well-child care including age-appropriate immunizations. Cost-sharing provisions pursuant to sections 208.631 to 208.657 shall not exceed the limits established by 42 U.S.C. Section 1397cc(e).