

FIRST REGULAR SESSION  
HOUSE COMMITTEE SUBSTITUTE FOR  
SENATE SUBSTITUTE FOR  
SENATE COMMITTEE SUBSTITUTE FOR  
**SENATE BILL NO. 577**  
**94TH GENERAL ASSEMBLY**

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

D. ADAM CRUMBLISS, Chief Clerk

2227L.07C

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**AN ACT**

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

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

Section A. Sections 105.711, 135.096, 191.411, 191.900, 191.905, 191.910, 198.097,  
2 208.014, 208.151, 208.152, 208.153, 208.201, 208.212, 208.215, 208.217, 208.225, 208.612,  
3 208.631, 208.640, 208.750, 208.930, 375.020, 473.398, 660.546, 660.547, 660.549, 660.551,  
4 660.553, 660.555, and 660.557, RSMo, are repealed and sixty-one new sections enacted in lieu  
5 thereof, to be known as sections 105.711, 135.096, 135.575, 167.182, 191.411, 191.900,  
6 191.905, 191.907, 191.908, 191.909, 191.910, 191.914, 191.1050, 191.1053, 191.1056, 192.632,  
7 198.069, 198.097, 208.001, 208.146, 208.151, 208.152, 208.153, 208.197, 208.201, 208.212,  
8 208.213, 208.215, 208.217, 208.225, 208.230, 208.612, 208.631, 208.640, 208.659, 208.670,

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

9 208.690, 208.692, 208.694, 208.696, 208.698, 208.750, 208.930, 208.950, 208.952, 208.954,  
10 208.956, 208.960, 208.962, 208.964, 208.968, 208.975, 208.978, 375.020, 375.143, 473.398,  
11 620.510, 1, 2, 3, and 4, to read as follows:

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

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

7 (1) The state of Missouri, or any agency of the state, pursuant to section 536.050 or  
8 536.087, RSMo, or section 537.600, RSMo;

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

15 (3) (a) Any physician, psychiatrist, pharmacist, podiatrist, dentist, nurse, or other health  
16 care provider licensed to practice in Missouri under the provisions of chapter 330, 332, 334, 335,  
17 336, 337 or 338, RSMo, who is employed by the state of Missouri or any agency of the state,  
18 under formal contract to conduct disability reviews on behalf of the department of elementary  
19 and secondary education or provide services to patients or inmates of state correctional facilities  
20 on a part-time basis, and any physician, psychiatrist, pharmacist, podiatrist, dentist, nurse, or  
21 other health care provider licensed to practice in Missouri under the provisions of chapter 330,  
22 332, 334, 335, 336, 337, or 338, RSMo, who is under formal contract to provide services to  
23 patients or inmates at a county jail on a part-time basis;

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

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

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

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

80 (e) Any physician, nurse, physician assistant, dental hygienist, or dentist licensed or  
81 registered to practice medicine, nursing, or dentistry or to act as a physician assistant or dental  
82 hygienist in Missouri under the provisions of chapter 332, RSMo, chapter 334, RSMo, or chapter  
83 335, RSMo, who provides medical, nursing, or dental treatment within the scope of his license  
84 or registration to students of a school whether a public, private, or parochial elementary or  
85 secondary school, if such physician's treatment is restricted to primary care and preventive health  
86 services and if such medical, dental, or nursing services are provided by the physician, dentist,  
87 physician assistant, dental hygienist, or nurse without compensation. In the case of any claim  
88 or judgment that arises under this paragraph, the aggregate of payments from the state legal  
89 expense fund shall be limited to a maximum of five hundred thousand dollars, for all claims  
90 arising out of and judgments based upon the same act or acts alleged in a single cause and shall  
91 not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased  
92 pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars;  
93 or

94 (f) **Any physician licensed under chapter 334, RSMo, or dentist licensed under**  
95 **chapter 332, RSMo, providing medical care without compensation to an individual**  
96 **referred to his or her care by a city or county health department organized under chapter**  
97 **192 or 205, RSMo, a city health department operating under a city charter, or a combined**  
98 **city-county health department, or nonprofit community health center qualified as exempt**  
99 **from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as**  
100 **amended, or a federally funded community health center organized under Section 315, 329,**  
101 **330, or 340 of the Public Health Services Act, 42 U.S.C. Section 216, 254c; provided that**  
102 **such treatment shall not include the performance of an abortion. In the case of any claim**  
103 **or judgment that arises under this paragraph, the aggregate of payments from the state**  
104 **legal expense fund shall be limited to a maximum of one million dollars, for all claims**

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

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

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

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

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

141 **health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336,**  
142 **337, or 338, RSMo,** for coverage concerning his or her private practice and assets shall not be  
143 considered available under subsection 7 of this section to pay that portion of a judgment or claim  
144 for which the state legal expense fund is liable under paragraph (a), (b), (c), (d), [or] (e), **or (f)**  
145 of subdivision (3) of subsection 2 of this section. However, a [physician, nurse, dentist,  
146 physician assistant, or dental hygienist] **health care professional licensed or registered under**  
147 **chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo,** may purchase liability or malpractice  
148 insurance for coverage of liability claims or judgments based upon care rendered under  
149 paragraphs (c), (d), [and] (e), **and (f)** of subdivision (3) of subsection 2 of this section which  
150 exceed the amount of liability coverage provided by the state legal expense fund under those  
151 paragraphs. Even if paragraph (a), (b), (c), (d), [or] (e), **or (f)** of subdivision (3) of subsection  
152 2 of this section is repealed or modified, the state legal expense fund shall be available for  
153 damages which occur while the pertinent paragraph (a), (b), (c), (d), [or] (e), **or (f)** of subdivision  
154 (3) of subsection 2 of this section is in effect. **Any health care professional licensed under**  
155 **chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, described in paragraph (a), (b),**  
156 **(c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section who is a defendant in a**  
157 **claim arising under paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection**  
158 **2 of this section shall have the right to consent to the settlement of the claim and shall not**  
159 **be forced to settle a particular claim.**

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

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

(1) Economic damages to any one claimant; and

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

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

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

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

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

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

222 9. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that  
223 is promulgated under the authority delegated in sections 105.711 to 105.726 shall become  
224 effective only if it has been promulgated pursuant to the provisions of chapter 536, RSMo.  
225 Nothing in this section shall be interpreted to repeal or affect the validity of any rule filed or  
226 adopted prior to August 28, 1999, if it fully complied with the provisions of chapter 536, RSMo.  
227 This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the  
228 general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to  
229 disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking  
230 authority and any rule proposed or adopted after August 28, 1999, shall be invalid and void.

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

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



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

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

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

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

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

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

17           **3. The department of revenue may promulgate rules to implement the provisions**  
18 **of this section. Any rule or portion of a rule, as that term is defined in section 536.010,**  
19 **RSMo, that is created under the authority delegated in this section shall become effective**  
20 **only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and,**  
21 **if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are**  
22 **nonseverable and if any of the powers vested with the general assembly pursuant to**  
23 **chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule**  
24 **are subsequently held unconstitutional, then the grant of rulemaking authority and any**  
25 **rule proposed or adopted after August 28, 2007, shall be invalid and void.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

69           7. No rule or portion of a rule promulgated under the authority of this section shall  
70 become effective unless it has been promulgated pursuant to the provisions of chapter 536,

71 **RSMo. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo,**  
72 **that is created under the authority delegated in this section shall become effective only if**  
73 **it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if**  
74 **applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable**  
75 **and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo,**  
76 **to review, to delay the effective date or to disapprove and annul a rule are subsequently**  
77 **held unconstitutional, then the grant of rulemaking authority and any rule proposed or**  
78 **adopted after August 28, 2007, shall be invalid and void.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22           (a) **Has actual knowledge of the information;**

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

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

25

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

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

36           [(9)] (10) "Person", a natural person, corporation, partnership, association or any legal  
37 entity.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

48           [8.] **9.** Each separate false statement or false representation of a material fact proscribed  
49 by subsection 1 of this section or act proscribed by subsection 2 or 3 of this section shall  
50 constitute a separate offense and a separate violation of this section, whether or not made at the  
51 same or different times, as part of the same or separate episodes, as part of the same scheme or  
52 course of conduct, or as part of the same claim.

53           [9.] **10.** In a prosecution pursuant to subsection 1 of this section, circumstantial evidence  
54 may be presented to demonstrate that a false statement or claim was knowingly made. Such  
55 evidence of knowledge may include but shall not be limited to the following:

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

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

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

62           [10.] **11.** Any person convicted of a violation of this section, in addition to any fines,  
63 penalties or sentences imposed by law, shall be required to make restitution to the federal and

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

92 [11.] **12.** A person who violates subsections 1 to [4] **3** of this section shall be liable for  
93 a civil penalty of not less than five thousand dollars and not more than ten thousand dollars for  
94 each separate act in violation of such subsections, plus three times the amount of damages which  
95 the state and federal government sustained because of the act of that person, except that the court  
96 may assess not more than two times the amount of damages which the state and federal  
97 government sustained because of the act of the person, if the court finds:

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



100 191.910 with all information known to such person about the violation within thirty days after  
101 the date on which the defendant first obtained the information;

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

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

108 [12.] **13.** Upon conviction pursuant to this section, the prosecution authority shall  
109 provide written notification of the conviction to all regulatory or disciplinary agencies with  
110 authority over the conduct of the defendant health care provider.

111 [13.] **14.** The attorney general may bring a civil action against any person who shall  
112 receive a health care payment as a result of a false statement or false representation of a material  
113 fact made or caused to be made by that person. The person shall be liable for up to double the  
114 amount of all payments received by that person based upon the false statement or false  
115 representation of a material fact, and the reasonable costs attributable to the prosecution of the  
116 civil action. All such restitution shall be paid and deposited to the credit of the [Medicaid] **MO**  
117 **HealthNet** fraud reimbursement fund, and all such cost reimbursements shall be paid and  
118 deposited to the credit of the [Medicaid] **MO HealthNet** fraud prosecution revolving fund. No  
119 reimbursement of such costs attributable to the prosecution of the civil action shall be made or  
120 allowed except with the approval of the court having jurisdiction of the civil action. No civil  
121 action provided by this subsection shall be brought if restitution and civil penalties provided by  
122 subsections 10 and 11 of this section have been previously ordered against the person for the  
123 same cause of action.

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

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

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

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

- 6           **(1) The court finds brought a frivolous or clearly vexatious claim;**  
7           **(2) The court finds to have planned, initiated, or participated in the conduct upon**  
8 **which the action is brought; or**  
9           **(3) Is convicted of criminal conduct arising from a violation of sections 191.900 to**  
10 **191.910.**

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

- 13           **(1) Reinstatement to the employee's position without loss of seniority;**  
14           **(2) Two times the amount of lost back pay;**  
15           **(3) Interest on the back pay at the rate of one percent over the prime rate.**

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

- 3           **(1) The number of provider investigations due to allegations of violations under**  
4 **sections 191.900 to 191.910 conducted by the attorney general's office and completed within**  
5 **the reporting year, including the age and type of cases;**  
6           **(2) The number of referrals due to allegations of violations under sections 191.900**  
7 **to 191.910 received by the attorney general's office;**  
8           **(3) The total amount of overpayments identified as the result of completed**  
9 **investigations;**  
10           **(4) The amount of fines and restitutions ordered to be reimbursed, with a**  
11 **delineation between amounts the provider has been ordered to repay, including whether**  
12 **or not such repayment will be completed in a lump sum payment or installment payments,**  
13 **and any adjustments or deductions ordered to future provider payments;**  
14           **(5) The total amount of monetary recovery as the result of completed investigations;**  
15           **(6) The total number of arrests, indictments, and convictions as the result of**  
16 **completed investigations.**

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

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

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

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

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

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

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

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

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

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

39  
40 **An annual financial audit of the program integrity unit within the department of social**  
41 **services shall be conducted and completed by the state auditor in order to quantitatively**  
42 **determine the amount of money invested in the unit and the amount of money actually**  
43 **recovered by such office.**

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

10 defined by section 578.375, RSMo. The attorney general and his **or her** authorized investigators  
11 shall be authorized to serve all subpoenas and civil process related to the enforcement of sections  
12 191.900 to 191.910 and chapter 407, RSMo. In order for the attorney general to commence a  
13 state prosecution for violations of sections 191.900 to 191.910, the attorney general shall prepare  
14 and forward a report of the violations to the appropriate prosecuting attorney. Upon receiving  
15 a referral, the prosecuting attorney shall either commence a prosecution based on the report by  
16 the filing of a complaint, information, or indictment within sixty days of receipt of said report  
17 or shall file a written statement with the attorney general explaining why criminal charges should  
18 not be brought. This time period may be extended by the prosecuting attorney with the  
19 agreement of the attorney general for an additional sixty days. If the prosecuting attorney  
20 commences a criminal prosecution, the attorney general or his designee shall be permitted by the  
21 court to participate as a special assistant prosecuting attorney in settlement negotiations and all  
22 court proceedings, subject to the authority of the prosecuting attorney, for the purpose of  
23 providing such assistance as may be necessary. If the prosecuting attorney fails to commence  
24 a prosecution and fails to file a written statement listing the reasons why criminal charges should  
25 not be brought within the appropriate time period, or declines to prosecute on the basis of  
26 inadequate office resources, the attorney general shall have authority to commence prosecutions  
27 for violations of sections 191.900 to 191.910. In cases where a defendant pursuant to a common  
28 scheme or plan has committed acts which constitute or would constitute violations of sections  
29 191.900 to 191.910 in more than one state, the attorney general shall have the authority to  
30 represent the state of Missouri in any plea agreement which resolves all criminal prosecutions  
31 within and without the state, and such agreement shall be binding on all state prosecutors.

32 2. In any investigation, hearing or other proceeding pursuant to sections 191.900 to  
33 191.910, any record in the possession or control of a health care provider, or in the possession  
34 or control of another person on behalf of a health care provider, including but not limited to any  
35 record relating to patient care, business or accounting records, payroll records and tax records,  
36 whether written or in an electronic format, shall be made available by the health care provider  
37 to the attorney general or the court, and shall be admissible into evidence, regardless of any  
38 statutory or common law privilege which such health care provider, record custodian or patient  
39 might otherwise invoke or assert. The provisions of section 326.151, RSMo, shall not apply to  
40 actions brought pursuant to sections 191.900 to 191.910. The attorney general shall not disclose  
41 any record obtained pursuant to this section, other than in connection with a proceeding instituted  
42 or pending in any court or administrative agency. The access, provision, use, and disclosure of  
43 records or material subject to the provisions of 42 U.S.C. section 290dd-2 shall be subject to said  
44 section, as may be amended from time to time, and to regulations promulgated pursuant to said  
45 section.

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

57           4. Sections 191.900 to 191.910 shall not be construed to prohibit or limit any other  
58 criminal or civil action against a health care provider for the violation of any other law. Any  
59 complaint, investigation or report received or completed pursuant to sections 198.070 and  
60 198.090, RSMo, subsection 2 of section 205.967, RSMo, sections 375.991 to 375.994, RSMo,  
61 section 578.387, RSMo, or sections 660.300 and 660.305, RSMo, which indicates a violation  
62 of sections 191.900 to 191.910, shall be referred to the attorney general. A referral to the  
63 attorney general pursuant to this subsection shall not preclude the agencies charged with  
64 enforcing the foregoing sections from conducting investigations, providing protective services  
65 or taking administrative action regarding the complaint, investigation or report referred to the  
66 attorney general, as may be provided by such sections; provided that all material developed by  
67 the attorney general in the course of an investigation pursuant to sections 191.900 to 191.910  
68 shall not be subject to subpoena, discovery, or other legal or administrative process in the course  
69 of any such administrative action. Sections 191.900 to 191.910 take precedence over the  
70 provisions of sections 198.070 and 198.090, RSMo, subsection 2 of section 205.967, RSMo,  
71 sections 375.991 to 375.994, RSMo, section 578.387, RSMo, and sections 660.300 and 660.305,  
72 RSMo, to the extent such provisions are inconsistent or overlap.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26           **5. Notwithstanding the provisions of section 33.080, RSMo, to the contrary, any**  
27 **moneys remaining in the fund at the end of the biennium shall not revert to the credit of**  
28 **the general revenue fund.**

29           **6. The state treasurer shall invest moneys in the fund in the same manner as other**  
30 **funds are invested. Any interest and moneys earned on such investments shall be credited**  
31 **to the fund.**

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

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

6           **(2) Two nephrologists;**

7           **(3) Two family physicians;**

8           **(4) Two pathologists;**

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

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

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

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

- 15           **(9) One member who represents the Missouri kidney program;**  
16           **(10) Two members of the house of representatives appointed by the speaker of the**  
17 **house;**  
18           **(11) Two members of the senate appointed by the president pro tem of the senate;**  
19           **(12) Additional members may be chosen to represent public health clinics,**  
20 **community health centers, and private health insurers.**  
21           **2. A chairperson and vice chairperson shall be elected by the members of the task**  
22 **force.**  
23           **3. The chronic kidney disease task force shall:**  
24           **(1) Develop a plan to educate the public and health care professionals about the**  
25 **advantages and methods of early screening, diagnosis, and treatment of chronic kidney**  
26 **disease and its complications based on kidney disease outcomes, quality initiative clinical**  
27 **practice guidelines for chronic kidney disease, or other medically recognized clinical**  
28 **practice guidelines;**  
29           **(2) Make recommendations on the implementation of a cost-effective plan for early**  
30 **screening, diagnosis, and treatment of chronic kidney disease for the state's population;**  
31           **(3) Identify barriers to adoption of best practices and potential public policy**  
32 **options to address such barriers;**  
33           **(4) Submit a report of its findings and recommendations to the general assembly**  
34 **by August 30, 2008.**  
35           **4. The department of health and senior services shall provide all necessary staff,**  
36 **research, and meeting facilities for the chronic kidney disease task force.**  
37           **5. The provisions of this section shall expire August 30, 2008.**  
          **198.069. For any resident of an assisted living facility who is released from a**  
2 **hospital or skilled nursing facility and returns to an assisted living facility as a resident,**  
3 **such resident's assisted living facility shall immediately, upon return, implement physician**  
4 **orders in the hospital or discharge summary, and within twenty-four hours of the patient's**  
5 **return to the facility, review and document such review of any physician orders related to**  
6 **the resident's hospital discharge care plan or the skilled nursing facilities discharge care**  
7 **plan and modify the individual service plan for the resident accordingly. The department**  
8 **of health and senior services may adjust personal care units authorized as described in**  
9 **subsection 14 of section 208.152, RSMo, upon the effective date of the physicians orders to**  
10 **reflect the services required by such orders.**  
          **198.097. 1. Any person who assumes the responsibility of managing the financial affairs**  
2 **of an elderly or disabled person who is a resident of [a nursing home] any facility licensed**  
3 **under this chapter shall be guilty of a class D felony if such person misappropriates the funds**



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

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

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

208.001. 1. Sections 191.411, 208.001, 208.151, 208.152, 208.153, 208.197, 208.201,  
2 208.202, 208.212, 208.215, 208.217, 208.631, 208.670, 208.690, 208.692, 208.694, 208.696,  
3 208.698, 208.930, 208.950, 208.955, 208.975, and 473.398, RSMo, may be known as and may  
4 be cited as the "Missouri Continuing Health Improvement Act".

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

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

14       4. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo,  
15 that is created under the authority delegated in the Missouri continuing health  
16 improvement act, shall become effective only if it complies with and is subject to all of the  
17 provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This sections  
18 and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general  
19 assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to  
20 disapprove and annul a rule are subsequently held unconstitutional, then the grant of  
21 rulemaking authority and any rule proposed or adopted after the effective date of the  
22 Missouri continuing health improvement act, shall be invalid and void.

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

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

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

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

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

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

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

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

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

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

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

38           (a) All earned income of the disabled worker;

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

41           (c) A twenty-dollar standard deduction;

42           (d) Health insurance premiums;

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

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

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

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

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

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

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

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

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

9           (2) All [recipients of] participants receiving aid to families with dependent children  
10 benefits, including all persons under nineteen years of age who would be classified as dependent

11 children except for the requirements of subdivision (1) of subsection 1 of section 208.040.  
12 **Participants eligible under this subdivision who are participating in drug court, as defined**  
13 **in section 478.001, RSMo, shall have their eligibility automatically extended sixty days**  
14 **from the time their dependent child is removed from the custody of the participant, subject**  
15 **to approval of the Centers for Medicare and Medicaid Services;**

16 (3) All [recipients of] **participants receiving** blind pension benefits;

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

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

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

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

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

34 (9) All persons who were [recipients of] **participants receiving** old age assistance  
35 benefits, aid to the permanently and totally disabled, or aid to the blind benefits on December 31,  
36 1973, and who continue to meet the eligibility requirements, except income, for these assistance  
37 categories, but who are no longer receiving such benefits because of the implementation of Title  
38 XVI of the federal Social Security Act, as amended;

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

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

44 (12) Pregnant women or infants under one year of age, or both, whose family income  
45 does not exceed an income eligibility standard equal to one hundred eighty-five percent of the

46 federal poverty level as established and amended by the federal Department of Health and  
47 Human Services, or its successor agency;

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

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

64 (15) The family support division shall not establish a resource eligibility standard in  
65 assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The  
66 [division of medical services] **MO HealthNet division** shall define the amount and scope of  
67 benefits which are available to individuals eligible under each of the subdivisions (12), (13), and  
68 (14) of this subsection, in accordance with the requirements of federal law and regulations  
69 promulgated thereunder;

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

73 (17) A child born to a woman eligible for and receiving [medical assistance] **MO**  
74 **HealthNet benefits** under this section on the date of the child's birth shall be deemed to have  
75 applied for [medical assistance] **MO HealthNet benefits** and to have been found eligible for  
76 such assistance under such plan on the date of such birth and to remain eligible for such  
77 assistance for a period of time determined in accordance with applicable federal and state law  
78 and regulations so long as the child is a member of the woman's household and either the woman  
79 remains eligible for such assistance or for children born on or after January 1, 1991, the woman  
80 would remain eligible for such assistance if she were still pregnant. Upon notification of such  
81 child's birth, the family support division shall assign a [medical assistance] **MO HealthNet**

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

84 (18) Pregnant women and children eligible for [medical assistance] **MO HealthNet**  
85 **benefits** pursuant to subdivision (12), (13) or (14) of this subsection shall not as a condition of  
86 eligibility for [medical assistance] **MO HealthNet** benefits be required to apply for aid to  
87 families with dependent children. The family support division shall utilize an application for  
88 eligibility for such persons which eliminates information requirements other than those necessary  
89 to apply for [medical assistance] **MO HealthNet benefits**. The division shall provide such  
90 application forms to applicants whose preliminary income information indicates that they are  
91 ineligible for aid to families with dependent children. Applicants for [medical assistance] **MO**  
92 **HealthNet** benefits under subdivision (12), (13) or (14) shall be informed of the aid to families  
93 with dependent children program and that they are entitled to apply for such benefits. Any forms  
94 utilized by the family support division for assessing eligibility under this chapter shall be as  
95 simple as practicable;

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

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

116 (21) Case management services for pregnant women and young children at risk shall be  
117 a covered service. To the greatest extent possible, and in compliance with federal law and

regulations, the department of health and senior services shall provide case management services to pregnant women by contract or agreement with the department of social services through local health departments organized under the provisions of chapter 192, RSMo, or chapter 205, RSMo, or a city health department operated under a city charter or a combined city-county health department or other department of health and senior services designees. To the greatest extent possible the department of social services and the department of health and senior services shall mutually coordinate all services for pregnant women and children with the crippled children's program, the prevention of mental retardation program and the prenatal care program administered by the department of health and senior services. The department of social services shall by regulation establish the methodology for reimbursement for case management services provided by the department of health and senior services. For purposes of this section, the term "case management" shall mean those activities of local public health personnel to identify prospective [Medicaid-eligible] **MO HealthNet-eligible** high-risk mothers and enroll them in the state's [Medicaid] **MO HealthNet** program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who participate in the [Medicaid] **MO HealthNet** program for prenatal care and to ensure that said high-risk mothers receive support from all private and public programs for which they are eligible and shall not include involvement in any [Medicaid] **MO HealthNet** prepaid, case-managed programs;

(22) By January 1, 1988, the department of social services and the department of health and senior services shall study all significant aspects of presumptive eligibility for pregnant women and submit a joint report on the subject, including projected costs and the time needed for implementation, to the general assembly. The department of social services, at the direction of the general assembly, may implement presumptive eligibility by regulation promulgated pursuant to chapter 207, RSMo. **By January 1, 2008, the department of social services shall study all significant aspects and report to the general assembly, the MO HealthNet oversight committee, and the joint committee on MO HealthNet on projected costs, short-term cost increases, long-term cost savings, and the time needed for implementation for:**

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

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

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

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

- 153 (e) Expanding the elderly and disabled waiver to participants under the age of  
154 sixty-three;
- 155 (f) Allowing participants of the elderly and disabled waiver to spend down to the  
156 waiver income limit;
- 157 (g) Expanding the Missouri Rx plan to Missouri residents sixty-five years of age or  
158 older and retired;
- 159 (h) Expanding eligibility for single adults without children;
- 160 (i) Enact the best practices from other states that appropriately place participants  
161 in an institutional care setting, including but not limited to the disparity between income  
162 eligibility for skilled nursing care versus home and community-based services; and
- 163 (j) Allowing nursing home residents who receive MO HealthNet benefits to retain  
164 not less than fifty dollars per month for discretionary spending;
- 165 (23) All [recipients] **participants** who would be eligible for aid to families with  
166 dependent children benefits except for the requirements of paragraph (d) of subdivision (1) of  
167 section 208.150;
- 168 (24) (a) All persons who would be determined to be eligible for old age assistance  
169 benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C.  
170 Section 1396a(f), or less restrictive methodologies as contained in the [Medicaid] **MO**  
171 **HealthNet** state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive  
172 income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change  
173 the income limit if authorized by annual appropriation;
- 174 (b) All persons who would be determined to be eligible for aid to the blind benefits  
175 under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section  
176 1396a(f), or less restrictive methodologies as contained in the [Medicaid] **MO HealthNet** state  
177 plan as of January 1, 2005, except that less restrictive income methodologies, as authorized in  
178 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of  
179 the federal poverty level;
- 180 (c) All persons who would be determined to be eligible for permanent and total disability  
181 benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C.  
182 1396a(f); or less restrictive methodologies as contained in the [Medicaid] **MO HealthNet** state  
183 plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income  
184 methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the  
185 income limit if authorized by annual appropriations. Eligibility standards for permanent and total  
186 disability benefits shall not be limited by age;



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

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

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

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

222 4. When any individual has been determined to be eligible for [medical assistance] **MO**  
223 **HealthNet benefits**, such medical assistance will be made available to him or her for care and  
224 services furnished in or after the third month before the month in which he made application for  
225 such assistance if such individual was, or upon application would have been, eligible for such  
226 assistance at the time such care and services were furnished; provided, further, that such medical  
227 expenses remain unpaid.

228 5. The department of social services may apply to the federal Department of Health and  
229 Human Services for a [Medicaid] **MO HealthNet** waiver amendment to the Section 1115  
230 demonstration waiver or for any additional [Medicaid] **MO HealthNet** waivers necessary not  
231 to exceed one million dollars in additional costs to the state. A request for such a waiver so  
232 submitted shall only become effective by executive order not sooner than ninety days after the  
233 final adjournment of the session of the general assembly to which it is submitted, unless it is  
234 disapproved within sixty days of its submission to a regular session by a senate or house  
235 resolution adopted by a majority vote of the respective elected members thereof.

236 6. Notwithstanding any other provision of law to the contrary, in any given fiscal year,  
237 any persons made eligible for [medical assistance] **MO HealthNet** benefits under subdivisions  
238 (1) to (22) of subsection 1 of this section shall only be eligible if annual appropriations are made  
239 for such eligibility. This subsection shall not apply to classes of individuals listed in 42 U.S.C.  
240 Section 1396a(a)(10)(A)(i).

208.152. 1. [Benefit] **MO HealthNet** payments [for medical assistance] shall be made  
2 on behalf of those eligible needy persons as defined in section 208.151 who are unable to provide  
3 for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the  
4 care or reasonable charge for the services as defined and determined by the [division of medical  
5 services] **MO HealthNet division**, unless otherwise hereinafter 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] **MO HealthNet division** shall provide through rule and regulation  
9 an exception process for coverage of inpatient costs in those cases requiring treatment beyond  
10 the seventy-fifth percentile professional activities study (PAS) or the [Medicaid] **MO HealthNet**  
11 children's diagnosis length-of-stay schedule; and provided further that the [division of medical  
12 services] **MO HealthNet division** shall take into account through its payment system for  
13 hospital services the situation of hospitals which serve a disproportionate number of low-income  
14 patients;

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

18 Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the  
19 [division of medical services] **MO HealthNet division** may evaluate outpatient hospital services  
20 rendered under this section and deny payment for services which are determined by the [division  
21 of medical services] **MO HealthNet division** not to be medically necessary, in accordance with  
22 federal law and regulations;

23 (3) Laboratory and X-ray services;

24 (4) Nursing home services for [recipients,] **participants, except to persons with more**  
25 **than five hundred thousand dollars equity in their home or** except [to] **for** persons in an  
26 institution for mental diseases who are under the age of sixty-five years, when residing in a  
27 hospital licensed by the department of health and senior services or a nursing home licensed by  
28 the department of health and senior services or appropriate licensing authority of other states or  
29 government-owned and -operated institutions which are determined to conform to standards  
30 equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C.  
31 301, et seq.), as amended, for nursing facilities. The [division of medical services] **MO**  
32 **HealthNet division** may recognize through its payment methodology for nursing facilities those  
33 nursing facilities which serve a high volume of [Medicaid] **MO HealthNet** patients. The  
34 [division of medical services] **MO HealthNet division** when determining the amount of the  
35 benefit payments to be made on behalf of persons under the age of twenty-one in a nursing  
36 facility may consider nursing facilities furnishing care to persons under the age of twenty-one  
37 as a classification separate from other nursing facilities;

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

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

48 (7) Drugs and medicines when prescribed by a licensed physician, dentist, or podiatrist;  
49 except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a  
50 licensed physician, dentist, or podiatrist may be made on behalf of any person who qualifies for  
51 prescription drug coverage under the provisions of P.L. 108-173;

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

54 (9) 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. 101-239 and  
58 federal regulations promulgated thereunder;

59 (10) Home health care services;

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

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

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

73 (14) Personal care services which are medically oriented tasks having to do with a  
74 person's physical requirements, as opposed to housekeeping requirements, which enable a person  
75 to be treated by his physician on an outpatient, rather than on an inpatient or residential basis in  
76 a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be  
77 rendered by an individual not a member of the [recipient's] **participant's** family who is qualified  
78 to provide such services where the services are prescribed by a physician in accordance with a  
79 plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal  
80 care services shall be those persons who would otherwise require placement in a hospital,  
81 intermediate care facility, or skilled nursing facility. Benefits payable for personal care services  
82 shall not exceed for any one [recipient] **participant** one hundred percent of the average statewide  
83 charge for care and treatment in an intermediate care facility for a comparable period of time.  
84 **Such services, when delivered in a residential care facility or assisted living facility licensed**  
85 **under chapter 198, RSMo, shall be authorized on a four-tier level based on the services the**  
86 **resident requires and the frequency of the services. A resident of such facility who**  
87 **qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a**  
88 **physician, qualify for the tier level with the fewest services. The rate paid to providers for**  
89 **each tier of service shall be set subject to appropriations;**

90 (15) Mental health services. The state plan for providing medical assistance under Title  
91 XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental  
92 health services when such services are provided by community mental health facilities operated  
93 by the department of mental health or designated by the department of mental health as a  
94 community mental health facility or as an alcohol and drug abuse facility or as a child-serving  
95 agency within the comprehensive children's mental health service system established in section  
96 630.097, RSMo. The department of mental health shall establish by administrative rule the  
97 definition and criteria for designation as a community mental health facility and for designation  
98 as an alcohol and drug abuse facility. Such mental health services shall include:

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

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

109 (c) Rehabilitative mental health and alcohol and drug abuse services including home and  
110 community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions  
111 rendered to individuals in an individual or group setting by a mental health or alcohol and drug  
112 abuse professional in accordance with a plan of treatment appropriately established,  
113 implemented, monitored, and revised under the auspices of a therapeutic team as a part of client  
114 services management. As used in this section, "mental health professional" and "alcohol and  
115 drug abuse professional" shall be defined by the department of mental health pursuant to duly  
116 promulgated rules.

117 With respect to services established by this subdivision, the department of social services,  
118 [division of medical services] **MO HealthNet division**, shall enter into an agreement with the  
119 department of mental health. Matching funds for outpatient mental health services, clinic mental  
120 health services, and rehabilitation services for mental health and alcohol and drug abuse shall be  
121 certified by the department of mental health to the [division of medical services] **MO HealthNet**  
122 **division**. The agreement shall establish a mechanism for the joint implementation of the  
123 provisions of this subdivision. In addition, the agreement shall establish a mechanism by which  
124 rates for services may be jointly developed;

125 (16) Such additional services as defined by the [division of medical services] **MO**  
126 **HealthNet division** to be furnished under waivers of federal statutory requirements as provided  
127 for and authorized by the federal Social Security Act (42 U.S.C. 301, et seq.) subject to  
128 appropriation by the general assembly;

129 (17) Beginning July 1, 1990, the services of a certified pediatric or family nursing  
130 practitioner **with a collaborative practice agreement** to the extent that such services are  
131 provided in accordance with [chapter] **chapters 334 and 335**, RSMo, and regulations  
132 promulgated thereunder[, regardless of whether the nurse practitioner is supervised by or in  
133 association with a physician or other health care provider];

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

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

140 a. The occupancy rate of the nursing home is at or above ninety-seven percent of  
141 [Medicaid] **MO HealthNet** certified licensed beds, according to the most recent quarterly census  
142 provided to the department of health and senior services which was taken prior to when the  
143 [recipient] **participant** is admitted to the hospital; and

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

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

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

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

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

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

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

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

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

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

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

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

198 [(4)] **(24)** Orthopedic devices or other prosthetics, including eye glasses, dentures,  
199 hearing aids, and wheelchairs. **Beginning January 1, 2008, such devices or prosthetics shall**  
200 **be subject to appropriations and shall be provided under the requirements in subdivision**  
201 **(19) of this subsection;**

202 **(25)** Services of physical therapists as defined in section 334.620, RSMo,  
203 occupational therapists as defined in section 324.050, RSMo, and speech therapists as  
204 defined in chapter 345, RSMo. Payments made by the MO HealthNet division for services  
205 outlined in this subdivision shall be subject to appropriations and may be subject to  
206 precertification. Precertification shall be based on best practices, as defined in section  
207 208.950 and shall be consistent with accepted standards of care, care and treatment  
208 guidelines, and peer-reviewed medical literature;

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

222 [(6)] **(26)** Comprehensive day rehabilitation services beginning early posttrauma as part  
223 of a coordinated system of care for individuals with disabling impairments. Rehabilitation  
224 services **shall be subject to appropriations and** must be based on an individualized,  
225 goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and  
226 monitored through an interdisciplinary assessment designed to restore an individual to optimal  
227 level of physical, cognitive, and behavioral function. The [division of medical services] **MO**  
228 **HealthNet division** shall establish by administrative rule the definition and criteria for  
229 designation of a comprehensive day rehabilitation service facility, benefit limitations and  
230 payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010,  
231 RSMo, that is created under the authority delegated in this subdivision shall become effective



only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void;

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

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

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

4. The division of medical services] **2. Beginning January 1, 2009, the MO HealthNet division may require any [recipient of medical assistance] participant receiving MO HealthNet benefits to pay [part of the charge or cost] an additional payment, as defined by rule duly promulgated by the [division of medical services] MO HealthNet division, for all covered services except for those services covered under subdivisions (14) and (15) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, RSMo, and a generic drug is substituted for a name brand drug, the [division of medical services] MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all [recipients the partial] participants the additional payment that may be required by the [division of medical services] MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by [recipients] participants under this section shall be**

268 [reduced from any] **in addition to and not in lieu of** payments made by the state for goods or  
269 services described herein except the [recipient] **participant** portion of the pharmacy professional  
270 dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may  
271 collect the co-payment at the time a service is provided or at a later date. A provider shall not  
272 refuse to provide a service if a [recipient] **participant** is unable to pay a required [cost sharing]  
273 **payment**. If it is the routine business practice of a provider to terminate future services to an  
274 individual with an unclaimed debt, the provider may include uncollected co-payments under this  
275 practice. Providers who elect not to undertake the provision of services based on a history of bad  
276 debt shall give [recipients] **participants** advance notice and a reasonable opportunity for  
277 payment. A provider, representative, employee, independent contractor, or agent of a  
278 pharmaceutical manufacturer shall not make co-payment for a [recipient] **participant**. This  
279 subsection shall not apply to other qualified children, pregnant women, or blind persons. If the  
280 Centers for Medicare and Medicaid Services does not approve the Missouri [Medicaid] **MO**  
281 **HealthNet** state plan amendment submitted by the department of social services that would  
282 allow a provider to deny future services to an individual with uncollected co-payments, the denial  
283 of services shall not be allowed. The department of social services shall inform providers  
284 regarding the acceptability of denying services as the result of unpaid co-payments.

285 [5.] **3.** The [division of medical services] **MO HealthNet division** shall have the right  
286 to collect medication samples from [recipients] **participants** in order to maintain program  
287 integrity.

288 [6.] **4.** Reimbursement for obstetrical and pediatric services under subdivision (6) of  
289 subsection 1 of this section shall be timely and sufficient to enlist enough health care providers  
290 so that care and services are available under the state plan for [medical assistance] **MO**  
291 **HealthNet benefits** at least to the extent that such care and services are available to the general  
292 population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. 1396a  
293 and federal regulations promulgated thereunder.

294 [7.] **5.** Beginning July 1, 1990, reimbursement for services rendered in federally funded  
295 health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404  
296 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations  
297 promulgated thereunder.

298 [8.] **6.** Beginning July 1, 1990, the department of social services shall provide  
299 notification and referral of children below age five, and pregnant, breast-feeding, or postpartum  
300 women who are determined to be eligible for [medical assistance] **MO HealthNet benefits**  
301 under section 208.151 to the special supplemental food programs for women, infants and  
302 children administered by the department of health and senior services. Such notification and

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

305 [9.] **7.** Providers of long-term care services shall be reimbursed for their costs in  
306 accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C.  
307 1396a, as amended, and regulations promulgated thereunder.

308 [10.] **8.** Reimbursement rates to long-term care providers with respect to a total change  
309 in ownership, at arm's length, for any facility previously licensed and certified for participation  
310 in the [Medicaid] **MO HealthNet** program shall not increase payments in excess of the increase  
311 that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42  
312 U.S.C. 1396a (a)(13)(C).

313 [11.] **9.** The [department of social services, division of medical services] **MO HealthNet**  
314 **division**, may enroll qualified residential care facilities **and assisted living facilities**, as defined  
315 in chapter 198, RSMo, as [Medicaid] **MO HealthNet** personal care providers.

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

208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151 and  
2 208.152, the [division of medical services] **MO HealthNet division** shall by rule and regulation  
3 define the reasonable costs, manner, extent, quantity, quality, charges and fees of [medical  
4 assistance] **MO HealthNet benefits** herein provided. The benefits available under these sections  
5 shall not replace those provided under other federal or state law or under other contractual or  
6 legal entitlements of the persons receiving them, and all persons shall be required to apply for  
7 and utilize all benefits available to them and to pursue all causes of action to which they are  
8 entitled. Any person entitled to [medical assistance] **MO HealthNet benefits** may obtain it from  
9 any provider of services with which an agreement is in effect under this section and which  
10 undertakes to provide the services, as authorized by the [division of medical services] **MO**  
11 **HealthNet division**. At the discretion of the director of [medical services] **the MO HealthNet**  
12 **division** and with the approval of the governor, the [division of medical services] **MO**  
13 **HealthNet division** is authorized to provide medical benefits for [recipients of] **participants**  
14 **receiving** public assistance by expending funds for the payment of federal medical insurance  
15 premiums, coinsurance and deductibles pursuant to the provisions of Title XVIII B and XIX,  
16 Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301 et seq.),  
17 as amended.

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

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

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

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

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

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

40 [3. Beginning July 1, 1990, medical assistance] 4. MO HealthNet shall include benefit  
41 payments for Medicare Part A cost sharing as defined in clause (p)(3)(A)(i) of 42 U.S.C. 1396d  
42 on behalf of qualified disabled and working individuals as defined in subsection (s) of section  
43 42 U.S.C. 1396d as required by subsection (d) of section 6408 of P.L. 101-239 (Omnibus Budget  
44 Reconciliation Act of 1989). The [division of medical services] MO HealthNet division may  
45 impose a premium for such benefit payments as authorized by paragraph (d)(3) of section 6408  
46 of P.L. 101-239.

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

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

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

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

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

**208.197. 1. The "Professional Services Payment Committee" is hereby established**  
2 **within the MO HealthNet division to guide, develop, and provide advice about the pay-for-**  
3 **performance payment program guidelines required under subsection 2 of section 208.153.**  
4 **The members of the committee shall be appointed by the governor no later than December**  
5 **31, 2007, and shall be subject to the advice and consent of the senate. The committee shall**  
6 **be composed of eighteen members, geographically balanced, including seven physicians**  
7 **licensed to practice in this state, one optometrist, one dentist, one podiatrist, one consumer**  
8 **advocate, one patient advocate, and two hospital administrators. The other members shall**  
9 **be one advance practice nurse and persons actively engaged in nursing home**  
10 **administration and in-home care. The members of the committee shall receive no**  
11 **compensation for their services other than expenses actually incurred in the performance**  
12 **of their official duties.**

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

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

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

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

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

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

26 [5.] 6. In addition to the powers, duties and functions vested in the [division of medical  
27 services] **MO HealthNet division** by other provisions of this chapter or by other laws of this  
28 state, the [division of medical services] **MO HealthNet division** shall have the power:

- 29 (1) To sue and be sued;
- 30 (2) To adopt, amend and rescind such rules and regulations necessary or desirable to  
31 perform its duties under state law and not inconsistent with the constitution or laws of this state;
- 32 (3) To make and enter into contracts and carry out the duties imposed upon it by this or  
33 any other law;
- 34 (4) To administer, disburse, accept, dispose of and account for funds, equipment,  
35 supplies or services, and any kind of property given, granted, loaned, advanced to or appropriated  
36 by the state of Missouri or the federal government for any lawful purpose;

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

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

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

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

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

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

208.212. 1. For purposes of [Medicaid] **MO HealthNet** eligibility, **the stream of**  
2 **income from** investment in annuities shall be [limited to] **excluded as an available resource**  
3 **for** those annuities that:

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

6 (2) Provide equal or nearly equal payments for the duration of the device and which  
7 exclude balloon-style final payments; [and]

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

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

12           2. The department shall establish a sixty month look-back period to review any  
13 investment in an annuity by an applicant for [Medicaid] **MO HealthNet** benefits. If an  
14 investment in an annuity is determined by the department to have been made in anticipation of  
15 obtaining or with an intent to obtain eligibility for [Medicaid] **MO HealthNet** benefits, the  
16 department shall have available all remedies and sanctions permitted under federal and state law  
17 regarding such investment. The fact that an investment in an annuity which occurred prior to  
18 August 28, 2005, does not meet the criteria established in subsection 1 of this section shall not  
19 automatically result in a disallowance of such investment.

20           3. The department of social services shall promulgate rules to administer the provisions  
21 of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo,  
22 that is created under the authority delegated in this section shall become effective only if it  
23 complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable,  
24 section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of  
25 the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay  
26 the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then  
27 the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall  
28 be invalid and void.

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

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

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

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

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

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

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



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

208.215. 1. [Medicaid] **MO HealthNet** is payer of last resort unless otherwise specified  
2 by law. When any person, corporation, institution, public agency or private agency is liable,  
3 either pursuant to contract or otherwise, to a [recipient of] **participant receiving** public  
4 assistance on account of personal injury to or disability or disease or benefits arising from a  
5 health insurance plan to which the [recipient] **participant** may be entitled, payments made by  
6 the department of social services **or MO HealthNet division** shall be a debt due the state and  
7 recoverable from the liable party or [recipient] **participant** for all payments made in behalf of  
8 the [recipient] **participant** and the debt due the state shall not exceed the payments made from  
9 [medical assistance] **MO HealthNet benefits** provided under sections 208.151 to 208.158 and  
10 section 208.162 and section 208.204 on behalf of the [recipient] **participant**, minor or estate for  
11 payments on account of the injury, disease, or disability or benefits arising from a health  
12 insurance program to which the [recipient] **participant** may be entitled. **Any health benefit**  
13 **plan as defined in section 376.1350, RSMo, third-party administrator, administrative**  
14 **services organization, and pharmacy benefit manager shall process and pay all properly**  
15 **submitted medical assistance subrogation claims or MO HealthNet subrogation claims for**  
16 **a period of at least three years from the date the services were provided or rendered,**  
17 **regardless of any other timely filing requirement otherwise imposed by such entity and the**  
18 **entity shall not deny such claims on the basis of the type or format of the claim form, or a**  
19 **failure to present proper documentation of coverage at the point of sale.**

20           2. The [department of social services] **MO HealthNet division** may maintain an  
21 appropriate action to recover funds **paid by the department of social services or MO**  
22 **HealthNet division that are** due under this section in the name of the state of Missouri against  
23 the person, corporation, institution, public agency, or private agency liable to the [recipient]  
24 **participant**, minor or estate.

25           3. Any [recipient] **participant**, minor, guardian, conservator, personal representative,  
26 estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful  
27 death who pursues legal rights against a person, corporation, institution, public agency, or private  
28 agency liable to that [recipient] **participant** or minor for injuries, disease or disability or benefits  
29 arising from a health insurance plan to which the [recipient] **participant** may be entitled as  
30 outlined in subsection 1 of this section shall upon actual knowledge that the department of social  
31 services **or MO HealthNet division** has paid [medical assistance] **MO HealthNet** benefits as  
32 defined by this chapter, promptly notify the [department] **MO HealthNet division** as to the  
33 pursuit of such legal rights.

34           4. Every applicant or [recipient] **participant** by application assigns his right to the  
35 department **of social services or MO HealthNet division** of any funds recovered or expected  
36 to be recovered to the extent provided for in this section. All applicants and [recipients]  
37 **participants**, including a person authorized by the probate code, shall cooperate with the  
38 [department of social services] **MO HealthNet division** in identifying and providing information  
39 to assist the state in pursuing any third party who may be liable to pay for care and services  
40 available under the state's plan for [medical assistance] **MO HealthNet benefits** as provided in  
41 sections 208.151 to 208.159 and sections 208.162 and 208.204. All applicants and [recipients]  
42 **participants** shall cooperate with the agency in obtaining third-party resources due to the  
43 applicant, [recipient] **participant**, or child for whom assistance is claimed. Failure to cooperate  
44 without good cause as determined by the department of social services, **MO HealthNet division**  
45 in accordance with federally prescribed standards shall render the applicant or [recipient]  
46 **participant** ineligible for [medical assistance] **MO HealthNet benefits** under sections 208.151  
47 to 208.159 and sections 208.162 and 208.204.

48           5. Every person, corporation or partnership who acts for or on behalf of a person who  
49 is or was eligible for [medical assistance] **MO HealthNet benefits** under sections 208.151 to  
50 208.159 and sections 208.162 and 208.204 for purposes of pursuing the applicant's or  
51 [recipient's] **participant's** claim which accrued as a result of a nonoccupational or  
52 nonwork-related incident or occurrence resulting in the payment of [medical assistance] **MO**  
53 **HealthNet** benefits shall notify the [department] **MO HealthNet division** upon agreeing to  
54 assist such person and further shall notify the [department] **MO HealthNet division** of any  
55 institution of a proceeding, settlement or the results of the pursuit of the claim and give thirty  
56 days' notice before any judgment, award, or settlement may be satisfied in any action or any  
57 claim by the applicant or [recipient] **participant** to recover damages for such injuries, disease,  
58 or disability, or benefits arising from a health insurance program to which the recipient may be  
59 entitled.

60           6. Every [recipient] **participant**, minor, guardian, conservator, personal representative,  
61 estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful  
62 death, or his attorney or legal representative shall promptly notify the [department] **MO**  
63 **HealthNet division** of any recovery from a third party and shall immediately reimburse the  
64 department **of social services, MO HealthNet division** from the proceeds of any settlement,  
65 judgment, or other recovery in any action or claim initiated against any such third party.

66           7. The department [director] **of social services, MO HealthNet division** shall have a  
67 right to recover the amount of payments made to a provider under this chapter because of an  
68 injury, disease, or disability, or benefits arising from a health insurance plan to which the

69 [recipient] **participant** may be entitled for which a third party is or may be liable in contract, tort  
70 or otherwise under law or equity.

71 8. The department of social services **or MO HealthNet division** shall have a lien upon  
72 any moneys to be paid by any insurance company or similar business enterprise, person,  
73 corporation, institution, public agency or private agency in settlement or satisfaction of a  
74 judgment on any claim for injuries or disability or disease benefits arising from a health  
75 insurance program to which the [recipient] **participant** may be entitled which resulted in  
76 medical expenses for which the department **or MO HealthNet division** made payment. This  
77 lien shall also be applicable to any moneys which may come into the possession of any attorney  
78 who is handling the claim for injuries, or disability or disease or benefits arising from a health  
79 insurance plan to which the [recipient] **participant** may be entitled which resulted in payments  
80 made by the department **or MO HealthNet division**. In each case, a lien notice shall be served  
81 by certified mail or registered mail, upon the party or parties against whom the applicant or  
82 [recipient] **participant** has a claim, demand or cause of action. The lien shall claim the charge  
83 and describe the interest the department **or MO HealthNet division** has in the claim, demand  
84 or cause of action. The lien shall attach to any verdict or judgment entered and to any money or  
85 property which may be recovered on account of such claim, demand, cause of action or suit from  
86 and after the time of the service of the notice. **If the third party and its liability insurer, if**  
87 **any, receives notice or knows that the individual is eligible for MO HealthNet benefits**  
88 **prior to release or satisfaction, no release or satisfaction of any cause of action, suit, claim,**  
89 **counterclaim, demand, judgment, settlement, or settlement agreement shall be valid or**  
90 **effectual as against a claim created under this chapter unless the division joins in the**  
91 **release or satisfaction or executes a release of its claim.**

92 9. On petition filed by the department, or by the [recipient] **participant**, or by the  
93 defendant, the court, on written notice of all interested parties, may adjudicate the rights of the  
94 parties and enforce the charge. The court may approve the settlement of any claim, demand or  
95 cause of action either before or after a verdict, and nothing in this section shall be construed as  
96 requiring the actual trial or final adjudication of any claim, demand or cause of action upon  
97 which the department has charge. The court may determine what portion of the recovery shall  
98 be paid to the department against the recovery. In making this determination the court shall  
99 conduct an evidentiary hearing and shall consider competent evidence pertaining to the following  
100 matters:

101 (1) The amount of the charge sought to be enforced against the recovery when expressed  
102 as a percentage of the gross amount of the recovery; the amount of the charge sought to be  
103 enforced against the recovery when expressed as a percentage of the amount obtained by  
104 subtracting from the gross amount of the recovery the total attorney's fees and other costs

105 incurred by the [recipient] **participant** incident to the recovery; and whether the department  
106 should, as a matter of fairness and equity, bear its proportionate share of the fees and costs  
107 incurred to generate the recovery from which the charge is sought to be satisfied;

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

111 (3) The total hospital, doctor and other medical expenses incurred for care and treatment  
112 of the injury to the date of recovery therefor, the portion of such expenses theretofore paid by the  
113 [recipient] **participant**, by insurance provided by the [recipient] **participant**, and by the  
114 department, and the amount of such previously incurred expenses which remain unpaid at the  
115 time of recovery and by whom such incurred, unpaid expenses are to be paid;

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

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

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

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

133 11. The court may reduce and apportion the department's **or MO HealthNet division's**  
134 lien proportionate to the recovery of the claimant. The court may consider the nature and extent  
135 of the injury, economic and noneconomic loss, settlement offers, comparative negligence as it  
136 applies to the case at hand, hospital costs, physician costs, and all other appropriate costs. The  
137 department **or MO HealthNet division** shall pay its pro rata share of the attorney's fees based  
138 on the department's **or MO HealthNet division's** lien as it compares to the total settlement  
139 agreed upon. This section shall not affect the priority of an attorney's lien under section 484.140,  
140 RSMo. The charges of the department **or MO HealthNet division or contractor** described in

141 this section, however, shall take priority over all other liens and charges existing under the laws  
142 of the state of Missouri with the exception of the attorney's lien under such statute.

143 12. Whenever the department of social services or MO HealthNet division has a statutory  
144 charge under this section against a recovery for damages incurred by a [recipient] **participant**  
145 because of its advancement of any assistance, such charge shall not be satisfied out of any  
146 recovery until the attorney's claim for fees is satisfied, irrespective of whether or not an action  
147 based on [recipient's] **participant's** claim has been filed in court. Nothing herein shall prohibit  
148 the director from entering into a compromise agreement with any [recipient] **participant**, after  
149 consideration of the factors in subsections 9 to 13 of this section.

150 13. This section shall be inapplicable to any claim, demand or cause of action arising  
151 under the workers' compensation act, chapter 287, RSMo. From funds recovered pursuant to this  
152 section the federal government shall be paid a portion thereof equal to the proportionate part  
153 originally provided by the federal government to pay for [medical assistance] **MO HealthNet**  
154 **benefits** to the [recipient] **participant** or minor involved. The department **or MO HealthNet**  
155 **division** shall enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and  
156 regulation on permanently institutionalized individuals. The department **or MO HealthNet**  
157 **division** shall have the right to enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal  
158 law and regulation on all other institutionalized individuals. For the purposes of this subsection,  
159 "permanently institutionalized individuals" includes those people who the department **or MO**  
160 **HealthNet division** determines cannot reasonably be expected to be discharged and return home,  
161 and "property" includes the homestead and all other personal and real property in which the  
162 [recipient] **participant** has sole legal interest or a legal interest based upon co-ownership of the  
163 property which is the result of a transfer of property for less than the fair market value within  
164 thirty months prior to the [recipient's] **participant's** entering the nursing facility. The following  
165 provisions shall apply to such liens:

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

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

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

179 (3) No such lien may be imposed against the property of any individual prior to [his] **the**  
180 **individual's** death on account of [medical assistance] **MO HealthNet benefits** paid except:

181 (a) In the case of the real property of an individual:

182 a. Who is an inpatient in a nursing facility, intermediate care facility for the mentally  
183 retarded, or other medical institution, if such individual is required, as a condition of receiving  
184 services in such institution, to spend for costs of medical care all but a minimal amount of his  
185 **or her** income required for personal needs; and

186 b. With respect to whom the director of the [department of social services] **MO**  
187 **HealthNet division** or the director's designee determines, after notice and opportunity for  
188 hearing, that he cannot reasonably be expected to be discharged from the medical institution and  
189 to return home. The hearing, if requested, shall proceed under the provisions of chapter 536,  
190 RSMo, before a hearing officer designated by the director of the [department of social services]  
191 **MO HealthNet division; or**

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

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

196 (a) The spouse of such individual;

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

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

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

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

208 15. Application for and acceptance of [medical assistance] **MO HealthNet benefits**  
209 under this chapter shall constitute an assignment to the department of social services **or MO**  
210 **HealthNet division** of any rights to support for the purpose of medical care as determined by a  
211 court or administrative order and of any other rights to payment for medical care.

212 16. All [recipients of] **participants receiving** benefits as defined in this chapter shall  
213 cooperate with the state by reporting to the **family support** division [of family services or the  
214 division of medical services] **or the MO HealthNet division**, within thirty days, any occurrences  
215 where an injury to their persons or to a member of a household who receives [medical assistance]  
216 **MO HealthNet benefits** is sustained, on such form or forms as provided by the **family support**  
217 division [of family services or the division of medical services] **or MO HealthNet division**.

218 17. If a person fails to comply with the provision of any judicial or administrative decree  
219 or temporary order requiring that person to maintain medical insurance on or be responsible for  
220 medical expenses for a dependent child, spouse, or ex-spouse, in addition to other remedies  
221 available, that person shall be liable to the state for the entire cost of the medical care provided  
222 pursuant to eligibility under any public assistance program on behalf of that dependent child,  
223 spouse, or ex-spouse during the period for which the required medical care was provided. Where  
224 a duty of support exists and no judicial or administrative decree or temporary order for support  
225 has been entered, the person owing the duty of support shall be liable to the state for the entire  
226 cost of the medical care provided on behalf of the dependent child or spouse to whom the duty  
227 of support is owed.

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

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

237 (2) **Total funds available for settlement; and**

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

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

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

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

7 (3) "Entity":

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

208.225. 1. To implement fully the provisions of section 208.152, the [division of  
2 medical services] **MO HealthNet division** shall calculate the [Medicaid] **MO HealthNet** per  
3 diem reimbursement rates of each nursing home participating in the [Medicaid] **MO HealthNet**  
4 program as a provider of nursing home services based on its costs reported in the Title XIX cost  
5 report filed with the [division of medical services] **MO HealthNet division** for its fiscal year as  
6 provided in subsection 2 of this section.

7 2. The recalculation of [Medicaid] **MO HealthNet** rates to all Missouri facilities will  
8 be performed as follows: effective July 1, 2004, the department of social services shall use the  
9 [Medicaid] **MO HealthNet** cost report containing adjusted costs for the facility fiscal year  
10 ending in 2001 and redetermine the allowable per-patient day costs for each facility. The  
11 department shall recalculate the class ceilings in the patient care, one hundred twenty percent of  
12 the median; ancillary, one hundred twenty percent of the median; and administration, one  
13 hundred ten percent of the median cost centers. Each facility shall receive as a rate increase  
14 one-third of the amount that is unpaid based on the recalculated cost determination.

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

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

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

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

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

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

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

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

21 (1) The name of the qualified employer;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

208.640. 1. Parents and guardians of uninsured children with incomes [between] **of more than** one hundred [fifty-one and] **fifty but less than** three hundred percent of the federal poverty level who do not have access to affordable employer-sponsored health care insurance or other affordable health care coverage may obtain coverage [pursuant to] **for their children under** this section. **Health insurance plans that do not cover an eligible child's preexisting condition shall not be considered affordable employer-sponsored health care insurance or other affordable health care coverage.** For the purposes of sections 208.631 to [208.657] **208.659**, "affordable employer-sponsored health care insurance or other affordable health care coverage" refers to health insurance requiring a monthly premium [less than or equal to one hundred thirty-three percent of the monthly average premium required in the state's current Missouri consolidated health care plan] **of:**

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

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

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

The parents and guardians of eligible uninsured children pursuant to this section are responsible for a monthly premium [equal to the average premium required for the Missouri consolidated health care plan] **as required by annual state appropriation**; provided that the total aggregate cost sharing for a family covered by these sections shall not exceed five percent of such family's income for the years involved. No co-payments or other cost sharing is permitted with respect to benefits for well-baby and well-child care including age-appropriate immunizations. Cost-sharing provisions [pursuant to] **for their children under** sections 208.631 to [208.657] **208.659** shall not exceed the limits established by 42 U.S.C. Section 1397cc(e). **If a child has exceeded the annual coverage limits for any needed health care service, the child is not considered insured and does not have access to affordable health insurance within the meaning of this section.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (1) MO HealthNet eligibility;

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

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

19 3. The department of social services shall:

20 (1) Within one hundred eighty days of the effective date of sections 208.690 to  
21 208.698, make application to the federal Department of Health and Human Services for a  
22 state plan amendment to establish a program that, in determining eligibility for state MO  
23 HealthNet benefits, provides for the disregard of any assets or resources in an amount  
24 equal to the insurance benefit payments that are made to or on behalf of an individual who  
25 is a beneficiary under a qualified long-term care insurance partnership policy; and

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

31 4. The department of social services shall promulgate rules to implement the  
32 provisions of sections 208.690 to 208.698. Any rule or portion of a rule, as that term is  
33 defined in section 536.010, RSMo, that is created under the authority delegated in this  
34 section shall become effective only if it complies with and is subject to all of the provisions  
35 of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter  
36 536, RSMo, are nonseverable and if any of the powers vested with the general assembly  
37 pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and  
38 annul a rule are subsequently held unconstitutional, then the grant of rulemaking

39 authority and any rule proposed or adopted after August 28, 2007, shall be invalid and  
40 void.

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

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

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

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

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

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

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

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

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

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



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

25 **2. The director of the department of insurance, financial institutions and**  
26 **professional registration shall promulgate rules to carry out the provisions of this section,**  
27 **and on the process for certifying the qualified long-term care partnership policies. Any**  
28 **rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created**  
29 **under the authority delegated in this section shall become effective only if it complies with**  
30 **and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section**  
31 **536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the**  
32 **powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to**  
33 **delay the effective date, or to disapprove and annul a rule are subsequently held**  
34 **unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted**  
35 **after August 28, 2007, shall be invalid and void.**

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

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

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

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

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

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

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

11 (5) "Family development account", a financial instrument established pursuant to section  
12 208.760;

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

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

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

22 (9) "Program", the Missouri family development account program established in sections  
23 208.750 to 208.775;

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

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

3 2. Subject to appropriations, the department may provide financial assistance for  
4 consumer-directed personal care assistance services through eligible vendors, as provided in  
5 sections 208.900 through 208.927, to each person who was participating as a [non-Medicaid]  
6 **nonMO HealthNet** eligible client pursuant to sections 178.661 through 178.673, RSMo, on June  
7 30, 2005, and who:

8 (1) Makes application to the department;

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

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

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

14 (5) Does not have access to affordable employer-sponsored health care insurance or other  
15 affordable health care coverage for personal care assistance services as defined in section  
16 208.900. For purposes of this section, "access to affordable employer-sponsored health care  
17 insurance or other affordable health care coverage" refers to health insurance requiring a monthly  
18 premium less than or equal to one hundred thirty-three percent of the monthly average premium  
19 required in the state's current Missouri consolidated health care plan.

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

22 3. (1) In order to be eligible for financial assistance for consumer-directed personal care  
23 assistance services under this section, a person shall demonstrate financial need, which shall be  
24 based on the adjusted gross income and the assets of the person seeking financial assistance and  
25 such person's spouse.

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

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

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

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

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

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

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

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

45 (5) Bank statements; and

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

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

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

56 7. (1) Nonpayment of the premium required in subsection 6 shall result in the denial or  
57 termination of assistance, unless the person demonstrates good cause for such nonpayment.

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

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

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

68 8. (1) Consumers determined eligible for personal care assistance services under the  
69 provisions of this section shall be reevaluated annually to verify their continued eligibility and  
70 financial need. The amount of financial assistance for consumer-directed personal care  
71 assistance services received by the consumer shall be adjusted or eliminated based on the  
72 outcome of the reevaluation. Any adjustments made shall be recorded in the consumer's personal  
73 care assistance services plan.

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

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

84 9. (1) Applicants for personal care assistance services and consumers receiving such  
85 services pursuant to this section are entitled to a hearing with the department of social services  
86 if eligibility for personal care assistance services is denied, if the type or amount of services is  
87 set at a level less than the consumer believes is necessary, if disputes arise after preparation of  
88 the personal care assistance plan concerning the provision of such services, or if services are  
89 discontinued as provided in section 208.924. Services provided under the provisions of this  
90 section shall continue during the appeal process.

91 (2) A request for such hearing shall be made to the department of social services in  
92 writing in the form prescribed by the department of social services within ninety days after the  
93 mailing or delivery of the written decision of the department of health and senior services. The  
94 procedures for such requests and for the hearings shall be as set forth in section 208.080.

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

98 11. The department may promulgate rules and regulations, including emergency rules,  
99 to implement the provisions of this section. Any rule or portion of a rule, as that term is defined

100 in section 536.010, RSMo, that is created under the authority delegated in this section shall  
101 become effective only if it complies with and is subject to all of the provisions of chapter 536,  
102 RSMo, and, if applicable, section 536.028, RSMo. Any provisions of the existing rules  
103 regarding the personal care assistance program promulgated by the department of elementary and  
104 secondary education in title 5, code of state regulations, division 90, chapter 7, which are  
105 inconsistent with the provisions of this section are void and of no force and effect.

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

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

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

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

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

13 (2) "Advisory committee", a committee of experts in a particular field, including  
14 but not limited to MO HealthNet providers whose duties shall include, but not be limited  
15 to making recommendations to the division on program improvements and cost efficiencies  
16 and who, after study of available pertinent literature, adopt the best practices guidelines  
17 used to determine medical necessity. Advisory committees include but shall not be limited  
18 to the medical and technical advisory committee and its subcommittees, established under  
19 section 208.195, the drug utilization review board, established under section 208.175, the  
20 prior authorization committee, established in 13 CSR 70-20.200, and the  
21 nonpharmaceutical mental health prior authorization advisory committee, established in  
22 13 CSR 70-98.020, and shall be required to meet as needed to ensure the best care of MO  
23 HealthNet participants;

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

30 pharmacy management, eligibility determination, provider network, and in which, for the  
31 delivery of goods and services covered under paragraph (c) of subdivision (15) of section  
32 208.152, the state shall retain care coordination, care management, utilization  
33 management, coverage and provider reimbursement;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

171 disabilities boards, centers for independent living, facilities licensed under chapter 198,  
172 RSMo, area agencies on aging, health care providers, and behavioral health providers;  
173 (30) "Nonmedical care", services provided to a participant that are not medical in  
174 nature but instead help the participant with routine tasks to allow the participant to live  
175 independently;  
176 (31) "Oversight committee", the MO HealthNet oversight committee created in  
177 section 208.956;  
178 (32) "Participant", a person determined to be eligible to receive MO HealthNet  
179 services under a category of coverage listed in subsection 1 of section 208.151 or section  
180 208.631;  
181 (33) "Primary care physician" or "PCP", a physician licensed under chapter 334,  
182 RSMo, who is a family practitioner, general practitioner, pediatrician, general internist,  
183 obstetrician, gynecologist or psychiatrist. A PCP shall be responsible for any care  
184 delivered to a participant by a PCP extender pursuant to a collaborative or supervisory  
185 agreement;  
186 (34) "Primary care physician extender", or "PCP extender", a licensed physician  
187 assistant or nurse practitioner who has a collaborative or supervisory agreement with a  
188 participant's chosen or assigned PCP, or by the entity which employs such PCP;  
189 (35) "Prior authorization system", or "PA system", a method used to determine  
190 whether or not services or equipment requested by a provider for delivery to a participant  
191 are medically necessary. The single state agency, when utilizing PA systems, shall ensure  
192 that they be transparent and subject to best practices, and as soon as possible, shall  
193 automate them into an electronic web-based format to increase timeliness and efficiency;  
194 (36) "Risk prediction", a procedure that uses risk factors or other statistical or  
195 scientific methods to predict, based upon a participant's health risk assessment and other  
196 known data, a participant's likelihood of developing certain illnesses, diseases outcomes  
197 or complications;  
198 (37) "State plan", "state point of service plan", "component state plan", or "basic  
199 state plan", a system of health care delivery designed by the state to ensure the coverage  
200 of medically necessary services prescribed under section 208.152 and any other budgeted  
201 service in which care to specific populations of participants is delivered on a point-of  
202 service basis and in which the state retains financial responsibility and oversees the  
203 administrative and care management activities internally or through contracted vendors.  
204 The state plan may be subdivided, and shall include a basic state plan, which shall be  
205 available everywhere in the state, and may include component plans, each made available  
206 to a specific subset of participants based upon geographic area, diagnosis or the results of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

49 9. The division shall be authorized, consistent with the provisions of sections  
50 208.962 and 208.964, using the lessons learned from the experience of other states and from  
51 any results obtained under subsections 10, 11 and 12 of this section, after consultation with  
52 the oversight committee, to design and implement new health improvement plans to cover  
53 defined populations of participants, subject to the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

80           **8. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo,**  
81 **that is created under the authority delegated in this section shall become effective only if**  
82 **it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if**  
83 **applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable**  
84 **and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo,**  
85 **to review, to delay the effective date, or to disapprove and annul a rule are subsequently**  
86 **held unconstitutional, then the grant of rulemaking authority and any rule proposed or**  
87 **adopted after August 28, 2007, shall be invalid and void.**

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

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

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

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

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

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

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

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

18           (8) One public member; and

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

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

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

37           (2) Review the participant and provider satisfaction reports required of the plan  
38 vendors under paragraph (c) of subdivision (1) of subsection 1 of section 208.954, and the  
39 reports of health and wellness outcomes and plan adjustments required under paragraph  
40 (b) of subdivision (2), paragraph (c) of subdivision (23), and subdivision (37) of section  
41 208.950;

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

44           (4) Review the results of pilot projects conducted under subsection 10 of section  
45 208.952;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

84           **(14) Ensure the division acts on directives issued;**

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

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

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

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

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

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

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

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

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

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

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

116           **5. The subcommittee shall include the following members:**

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

- 119           (2) One member from a Missouri area agency on aging, designated by the  
120 governor;
- 121           (3) One member representing the in-home care profession, designated by the  
122 governor;
- 123           (4) One member representing residential care facilities, predominantly serving MO  
124 HealthNet participants, designated by the governor;
- 125           (5) One member representing assisted living facilities or continuing care retirement  
126 communities, predominantly serving MO HealthNet participants, designated by the  
127 governor;
- 128           (6) One member representing skilled nursing facilities, predominantly serving MO  
129 HealthNet participants, designated by the governor;
- 130           (7) One member from the office of the state ombudsman for long-term care facility  
131 residents, designated by the governor;
- 132           (8) One member representing Missouri centers for independent living, designated  
133 by the governor;
- 134           (9) One consumer representative with expertise in services for seniors or the  
135 disabled, designated by the governor;
- 136           (10) One member with expertise in Alzheimer's disease or related dementia;
- 137           (11) One member from a county developmental disability board, designated by the  
138 governor;
- 139           (12) One member representing the hospice care profession, designated by the  
140 governor;
- 141           (13) One member representing the home health care profession, designated by the  
142 governor;
- 143           (14) One member representing the adult day care profession, designated by the  
144 governor;
- 145           (15) One member gerontologist, designated by the governor;
- 146           (16) Two members representing the aged, blind, and disabled population, not of the  
147 same geographic area or demographic group designated by the governor;
- 148           (17) The directors of the departments of social services, mental health, and health  
149 and senior services, or their designees; and
- 150           (18) One member of the house of representatives and one member of the senate  
151 serving on the oversight committee, designated by the oversight committee chair.
- 152
- 153 Members shall serve on the subcommittee without compensation but may be reimbursed  
154 for their actual and necessary expenses from moneys appropriated to the department of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14           (6) A senator chosen by the president pro tem of the senate.  
15

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

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

18           3. The committee shall meet as necessary.

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

208.968. The division, in conjunction with the department of health and senior  
2 services, shall develop a universal information and assessment system as defined in section  
3 208.950 that allows Missourians to receive information, assessments and assistance  
4 concerning long-term care services through the department of health and senior services  
5 and through natural points of entry. The division shall work with provider groups and  
6 advocates to begin development of the system design as of the effective date of this section.  
7 The division shall contract by March 1, 2008, with a vendor or vendors to provide a system  
8 that allows for web-based access and seamless access through the web-based electronic  
9 patient health record to be in operation by December 31, 2008. The universal information  
10 and assessment system shall be available to Missourians through the department of health  
11 and senior services and natural points of entry and shall assure uniform and transparent  
12 application of assessments, determinations, care plans, and service authorization. The  
13 universal information and assessment system shall include, but not be limited to:

- 14           (1) An information system accessible via the Internet, by phone or in-person that  
15 promotes access to good quality care by connecting Missourians regardless of their income  
16 to a full range of HCBS, residential, and institutional services statewide;
- 17           (2) Electronic communication between the department of health and senior  
18 services, long-term care providers, health care and behavioral health care providers, and  
19 natural points of entry;
- 20           (3) Electronic access for providers to best practice guideline for long-term care;
- 21           (4) The independence screening to determine the risk of being inappropriately  
22 moved to a more restrictive and less cost effective care setting;
- 23           (5) A screening and application process accessible via the Internet, by phone or  
24 in-person to determine the likelihood of MO HealthNet financial eligibility and the  
25 automatic connection with the family support division for the application process to begin;
- 26           (6) Guidelines for determination of level of care needs available electronically;
- 27           (7) Allowing electronic submission of level of care needs data for MO HealthNet  
28 HCBS eligibility determination;
- 29           (8) Electronic data submission for transparent, electronic care plan development  
30 based on best practices to address the patient's long-term care needs with medical and  
31 nonmedical long-term care services;
- 32           (9) Electronic authorization of long-term care services, including but not limited  
33 to, in-home care services, personal care attendant services, residential care facility and  
34 assisted living facility tiered care levels, home health care, adult day care, aged and  
35 disabled waiver services, AIDS waiver services, physical disability waiver services,  
36 independent living waiver services;
- 37           (10) An electronic request and authorization process for long-term care service  
38 modifications;
- 39           (11) Data collection and analysis functions on consumers, providers and services  
40 that allows utilization review; and
- 41           (12) An electronic bill submission and payment system for long-term care services.
- 208.975. 1. There is hereby created in the state treasury the "Health Care  
2 Technology Fund" which shall consist of all gifts, donations, transfers, and moneys  
3 appropriated by the general assembly, and bequests to the fund. The state treasurer shall  
4 be custodian of the fund and may approve disbursements from the fund in accordance with  
5 sections 30.170 and 30.180, RSMo. The fund shall be administered by the department of  
6 social services in accordance with the recommendations of the MO HealthNet oversight  
7 committee unless otherwise specified by the general assembly. Moneys in the fund shall  
8 be distributed in accordance with specific appropriation by the general assembly. The

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

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

- 18 (1) Electronic medical records;
- 19 (2) Community health records;
- 20 (3) Personal health records;
- 21 (4) E-prescribing;
- 22 (5) Telemedicine;
- 23 (6) Telemonitoring; and
- 24 (7) Electronic access for participants and providers to obtain MO HealthNet service  
25 authorizations.

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

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

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

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

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

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

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

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

68       10. The state treasurer shall invest moneys in the fund in the same manner as other  
69 funds are invested. Any interest and moneys earned on such investments shall be credited  
70 to the fund.

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

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

81 HealthNet or are from the medically underserved population. Any rule or portion of a  
82 rule, as that term is defined in section 536.010, RSMo, that is created under the authority  
83 delegated in this section shall become effective only if it complies with and is subject to all  
84 of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This  
85 section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the  
86 general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or  
87 to disapprove and annul a rule are subsequently held unconstitutional, then the grant of  
88 rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be  
89 invalid and void.

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

- 19           (1) American College Courses (CLU, ChFC);  
20           (2) Life Underwriters Training Council (LUTC);  
21           (3) Certified Insurance Counselor (CIC);  
22           (4) Chartered Property and Casualty Underwriter (CPCU);  
23           (5) Insurance Institute of America (IIA);  
24           (6) **Any other professional financial designation approved by the director by rule;**  
25           (7) An insurance-related course taught by an accredited college or university or qualified  
26 instructor who has taught a course of insurance law at such institution;

27           [(7)] (8) A course or program of instruction or seminar developed or sponsored by any  
28 authorized insurer, recognized producer association or insurance trade association. A local  
29 producer group may also be approved if the instructor receives no compensation for services.

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

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

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

- 42           (1) Serious physical injury or illness;
- 43           (2) Active duty in the armed services for an extended period of time;
- 44           (3) Residence outside the United States; or
- 45           (4) The licensee is at least seventy years of age.

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

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

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

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

66 (1) Course content and hour credits: The insurance advisory board established by section  
67 375.019 shall be utilized by the director to assist him in determining acceptable content of  
68 courses, programs and seminars to include classroom equivalency;

69 (2) Filing fees for course approval: Every applicant seeking approval by the director of  
70 a continuing education course under this section shall pay to the director a filing fee of fifty  
71 dollars per course. Fees shall be waived for state and local insurance producer groups. Such fee  
72 shall accompany any application form required by the director. Courses shall be approved for  
73 a period of no more than one year. Applicants holding courses intended to be offered for a  
74 longer period must reapply for approval. Courses approved by the director prior to August 28,  
75 1993, for which continuous certification is sought should be resubmitted for approval sixty days  
76 before the anniversary date of the previous approval.

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

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

473.398. 1. Upon the death of a person, who has been a [recipient] **participant** of aid,  
2 assistance, care, services, or who has had moneys expended on his behalf by the department of  
3 health and senior services, department of social services, or the department of mental health, or  
4 by a county commission, the total amount paid to the decedent or expended upon his behalf after  
5 January 1, 1978, shall be a debt due the state or county, as the case may be, from the estate of the  
6 decedent. The debt shall be collected as provided by the probate code of Missouri, chapters 472,  
7 473, 474 and 475, RSMo.

8 2. Procedures for the allowance of such claims shall be in accordance with this chapter,  
9 and such claims shall be allowed as a claim of the seventh class under subdivision (7) of section  
10 473.397.

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

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

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

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

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

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

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

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

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

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

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

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

13           **3. The commission shall consist of the following members:**

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

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

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

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

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

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

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

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

28

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

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

40           5. The commission shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12       (5) Projected financial need going forward.

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

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

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

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

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

[208.014. 1. There is hereby established the "Medicaid Reform  
2 Commission". The commission shall have as its purpose the study and review  
3 of recommendations for reforms of the state Medicaid system. The commission  
4 shall consist of ten members:

5 (1) Five members of the house of representatives appointed by the  
6 speaker; and

7 (2) Five members of the senate appointed by the pro tem.

8 No more than three members from each house shall be of the same political party.  
9 The directors of the department of social services, the department of health and  
10 senior services, and the department of mental health or the directors' designees  
11 shall serve as ex officio members of the commission.

12 2. Members of the commission shall be reimbursed for the actual and  
13 necessary expenses incurred in the discharge of the member's official duties.

14 3. A chair of the commission shall be selected by the members of the  
15 commission.

16 4. The commission shall meet as necessary.

17           5. The commission is authorized to contract with a consultant. The  
18 compensation of the consultant and other personnel shall be paid from the joint  
19 contingent fund or jointly from the senate and house contingent funds until an  
20 appropriation is made therefor.

21           6. The commission shall make recommendations in a report to the  
22 general assembly by January 1, 2006, on reforming, redesigning, and  
23 restructuring a new, innovative state Medicaid healthcare delivery system under  
24 Title XIX, Public Law 89-97, 1965, amendments to the federal Social Security  
25 Act (42 U.S.C. Section 30 et. seq.) as amended, to replace the current state  
26 Medicaid system under Title XIX, Public Law 89-97, 1965, amendments to the  
27 federal Social Security Act (42 U.S.C. Section 30, et seq.), which shall sunset on  
28 June 30, 2008.]  
29

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

11           (1) His eligibility for Medicaid;

12           (2) The amount of any Medicaid payment.

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

15           2. Notwithstanding any provision of law to the contrary, for purposes of  
16 recovering any medical assistance paid on behalf of an individual who was  
17 allowed an asset or resource disregard based on such long-term care insurance  
18 policy, the definition of estate shall be expanded to include any other real or  
19 personal property and other assets in which the individual has any legal title or  
20 interest at the time of death, to the extent of such interest, including such assets  
21 conveyed to a survivor, heir, or assign of the deceased individual through joint  
22 tenancy, tenancy in common, survivorship, life estate, living trust or other  
23 arrangement.]  
24

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



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

- 15 (1) For services Medicaid approves or covers for its recipients;
- 16 (2) In an amount not in excess of the charges of the health services  
17 provider;
- 18 (3) For nursing home care, or formal services delivered to insureds in the  
19 community as part of a care plan approved by a coordination, assessment and  
20 monitoring agency licensed pursuant to chapter 198, RSMo; and
- 21 (4) For services provided after the individual meets the coverage  
22 requirements for long-term care benefits established by the department of social  
23 services for this program.

24 The director of the department of social services shall adopt regulations in  
25 accordance with chapter 536, RSMo, to implement the provisions of sections  
26 660.546 to 660.557, relating to determining eligibility of applicants for Medicaid  
27 and the coverage requirements for long-term care benefits.]  
28

2 [660.549. The department of social services shall establish an outreach  
program to educate consumers to:

- 3 (1) The mechanisms for financing long-term; and
- 4 (2) The asset protection provided under sections 660.546 to 660.557.]  
5

2 [660.551. 1. The department of insurance shall precertify long-term care  
insurance policies which are issued by insurers who, in addition to complying  
3 with other relevant laws and regulations:

- 4 (1) Alert the purchaser to the availability of consumer information and  
5 public education provided by the division of aging and the department of  
6 insurance pursuant to sections 660.546 to 660.557;
- 7 (2) Offer the option of home- and community-based services in lieu of  
8 nursing home care;
- 9 (3) Offer automatic inflation protection or optional periodic per diem  
10 upgrades until the insured begins to receive long-term care benefits; provided,  
11 however, that such inflation protection or upgrades shall not be required of life  
12 insurance policies or riders containing accelerated long-term care benefits;
- 13 (4) Provide for the keeping of records and an explanation of benefits  
14 reports to the insured and the department of insurance on insurance payments  
15 which count toward Medicaid resource exclusion; and

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

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

23 2. No policy shall be precertified pursuant to sections 660.546 to  
24 660.557, if it requires prior hospitalization or a prior stay in a nursing home as  
25 a condition of providing benefits.

26 3. The department of insurance may adopt regulations to carry out the  
27 provisions of sections 660.546 to 660.557.]  
28

2 [660.553. The department of insurance shall provide public information  
3 to assist individuals in choosing appropriate insurance coverage, and shall  
4 establish an outreach program to educate consumers as to:

- 5 (1) The need for long-term; and  
6 (2) The availability of long-term care insurance.]

2 [660.555. The director of the department of insurance each year, on  
3 January first shall report in writing to the department of social services the  
4 following information:

- 5 (1) The success in implementing the provisions of sections 660.546 to  
6 660.557;  
7 (2) The number of policies precertified pursuant to sections 660.546 to  
8 660.557;  
9 (3) The number of individuals filing consumer complaints with respect  
10 to precertified policies; and  
11 (4) The extent and type of benefits paid, in the aggregate, under such  
12 policies that could count toward Medicaid resource protection.]

2 [660.557. The director of the department of social services shall request  
3 the federal approvals necessary to carry out the purposes of sections 660.546 to  
4 660.557. Each year on January first, the director of the department of social  
5 services shall report in writing to the general assembly on the progress of the  
6 program. Such report will include, but not be limited to:

- 7 (1) The success in implementing the provisions of sections 660.546 to  
8 660.557;  
9 (2) The number of policies precertified pursuant to sections 660.546 to  
10 660.557;  
11 (3) The number of individuals filing consumer complaints with respect  
to precertified policies;

- 12                   (4) The extent and type of benefits paid, in the aggregate, under such  
13 policies that could count toward Medicaid resource protection;  
14                   (5) Estimates of impact on present and future Medicaid expenditures;  
15                   (6) The cost effectiveness of the program; and  
16                   (7) A recommendation regarding the appropriateness of continuing the  
17 program.]  
18

Section B. Because immediate action is necessary to ensure that the youth aging out of  
2 foster care are able to obtain services, the repeal and reenactment of section 208.151 of this act  
3 is deemed necessary for the immediate preservation of the public health, welfare, peace and  
4 safety, and is hereby declared to be an emergency act within the meaning of the constitution, and  
5 the repeal and reenactment of section 208.151 of this act shall be in full force and effect upon  
6 its passage and approval.

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