House _____ **Amendment NO.____**

Offered By

_____ _____

AMEND House Committee Substitute for Senate Bill No. 508, Page 2, Section 43.530, Line 23, by inserting after all of said section and line the following:

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

2. There is hereby created in the state treasury the "Health Access Incentive Fund". Moneys in the fund shall be used to implement and encourage a program to fund loans, loan repayments, start-up grants, provide locum tenens, professional liability insurance assistance, practice subsidy, annuities when appropriate, or technical assistance in exchange for location of appropriate health providers, including dentists, who agree to serve all persons in need of health services regardless of ability to pay. The department of health and senior services shall encourage the recruitment of minorities in implementing this program.

3. In accordance with an agreement approved by both the director of the department of social services and the director of the department of health and senior services, the commissioner of the office of administration shall issue warrants to the state treasurer to transfer available funds from the health access incentive fund to the department of social services to be used to enhance MO HealthNet payments to physicians, dentists, psychiatrists, psychologists, or other mental health providers licensed under chapter 337 in order to enhance the availability of physician, dental, or mental health services in shortage areas. The amount that may be transferred shall be the amount agreed upon by the directors of the departments of social services and health and senior services and shall not exceed the maximum amount specifically authorized for any such transfer by appropriation of the general assembly.

4. The general assembly shall appropriate money to the health access incentive fund from the health initiatives fund created by section 191.831. The health access incentive fund shall also

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contain money as otherwise provided by law, gift, bequest or devise. Notwithstanding the provisions of section 33.080, the unexpended balance in the fund at the end of the biennium shall not be transferred to the general revenue fund of the state.

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

6. The department of health and senior services shall submit an annual report to the **[**oversight committee created under section 208.955**]** joint committee on MO HealthNet created under section 208.952 regarding the implementation of the plan developed under this section.

191.870. 1. For purposes of this section, the following terms shall mean:

(1) "Enrollee:, shall have the same meaning ascribed to it in section 376.1350;

(2) "Health care provider", shall have the same meaning ascribed to it in section 376.1350;

(3) "Health care service", shall have the same meaning ascribed to it in section 376.1350;

(4) "Health carrier", shall have the same meaning ascribed to it in section 376.1350.

2. Upon request from a patient, potential patient, or such person's parent or legal guardian, a health care provider shall provide an estimated cost, if known, for a health care service based on the patient's or potential patient's health benefit plan coverage, MO HealthNet coverage, Medicare coverage, or uninsured status. If covered by a health benefit plan, MO HealthNet, or Medicare, the health care provider shall provide the contractual reimbursement rate for the service, if known, and, if applicable, the amount the patient or potential patient would pay as a result of a deductible, coinsurance, or co-payment. If a patient or potential patient is uninsured, the health care provider shall provide the estimated out-of-pocket cost and information regarding any payment plan or other financial assistance that may be available. The health care provider's response need not be in writing unless the patient, potential patient, or such person's parent or legal guardian requests a written response.

3. Health care providers providing estimated costs under subsection 1 of this section shall include with any price quote the following statement:

"Your estimated cost is based on the information entered and assumptions about typical utilization and costs. The actual amount billed to you may be different from the estimate of costs provided to you. Many factors affect the actual bill you will receive and this estimate of costs does not account for all of them. Additionally, the estimate of costs is not a guarantee of insurance coverage. You will be billed at the provider's charge for any service provided to you that is not a covered benefit under your plan. Please check with your insurance company if you need help understanding your benefits for the service chosen.".

4. No provision in a contract entered into, amended, or renewed on or after August 28, 2014, between a health carrier and a health care provider shall be enforceable if such contractual provision prohibits, conditions, or in any way restricts any party to such contract from disclosing to an enrollee, patient, potential patient, or such person's parent or legal guardian the contractual reimbursement rate for a health care service if such payment amount is less than the health care provider's usual charge for the health care service and if such contractual provision prevents the determination of the potential out-of-pocket cost for the health care service by the enrollee, patient, potential patient, parent, or legal guardian.

5. Any violation of the provisions of this section shall result in a fine not to exceed one thousand dollars for each instance of violation.

191.875. 1. On or after July 1, 2015, any patient or consumer of health care services, or any MO HealthNet recipient or the division on behalf of a MO HealthNet recipient who makes a request for an estimate of the cost of health care services from a health care provider shall be provided such estimate no later than five business days after receiving such request, except when the requested information is posted on the department's website under subsections 7 to 11 of this section. The provisions of this subsection shall not apply to emergency health care services.

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

(1) "Ambulatory surgical center", any ambulatory surgical center as defined in section 197.200;

(2) "CPT code", the Current Procedure Terminology code;

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

(4) "DRG", diagnosis related group;

(5) "Estimate of cost", an estimate based on the information entered and assumptions about typical utilization and costs for health care services. Such estimate of cost shall include the following:

(a) The amount that will be charged to a patient for the health services if all charges are paid in full without a public or private third party paying for any portion of the charges;

(b) The average negotiated settlement on the amount that will be charged to a patient required to be provided in paragraph (a) of this subdivision;

(c) The amount of any MO HealthNet reimbursement for the health care services, including claims and pro rata supplemental payments, if known;

(d) The amount of any Medicare reimbursement for the medical services, if known; and

(e) The amount of any insurance co-payments for the health benefit plan of the patient, if known;

(6) "Health care provider", any hospital, ambulatory surgical center, physician, dentist, clinical psychologist, pharmacist, optometrist, podiatrist, registered nurse, physician assistant, chiropractor, physical therapist, nurse anesthetist, long-term care facility, or other licensed health care facility or professional providing health care services in this state;

(7) "Health carrier", an entity as such term is defined under section 376.1350;

(8) "Public or private third party", a state government, the federal government, employer, health carrier, third-party administrator, or managed care organization.

3. Health care providers and the department shall include with any estimate of cost the following: "Your estimated cost is based on the information entered and assumptions about typical utilization and costs. The actual amount billed to you may be different from the estimate of cost provided to you. Many factors affect the actual bill you will receive, and this estimate of cost does not account for all of them. Additionally, the estimate of cost is not a guarantee of insurance coverage or payment of benefits by a public or private third party. You will be billed at the provider's charge for any service provided to you that is not a covered benefit under your plan or by a public or private third party. Please check with your insurance company or public or private third

party to receive an estimate of the amount you will owe under your plan or if you need help understanding your benefits for the service chosen.".

4. Each health care provider shall also make available the percentage or amount of any discounts for cash payment of any charges incurred by a posting on the provider's website and by making it available at the provider's location.

5. Nothing in this section shall be construed as violating any provider contract provisions with a health carrier that prohibit disclosure of the provider's fee schedule with a health carrier to third parties.

6. The department may promulgate rules to implement the provisions of subsections 1 to 5 of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

7. A hospital may provide the information specified in subsections 7 to 11 of this section to the department. A hospital which does so shall not be required to provide such information under subsection 1 of this section.

8. The department shall make available to the public on its internet website the most current price information it receives from hospitals under subsections 9 and 10 of this section. The department shall provide such information in a manner that is easily understood by the public and meets the following minimum requirements:

(1) Information for each participating hospital shall be listed separately and hospitals shall be listed in groups by category as determined by the department by rule;

(2) Information for each hospital outpatient department shall be listed separately.

9. Any data disclosed to the department by a hospital under subsections 10 and 11 of this section shall be the sole property of the hospital that submitted the data. Any data or product derived from the data disclosed under subsections 7 to 11 of this section, including a consolidation or analysis of the data, shall be the sole property of the state. The department shall not allow proprietary information it receives or discloses under subsections 7 to 11 of this section to be used by any person or entity for commercial purposes.

10. Beginning with the quarter ending June 30, 2015, and quarterly thereafter, each participating hospital shall provide to the department, in the manner and format determined by the department, the following information about the one hundred most frequently reported admissions by DRG for inpatients as established by the department:

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges;

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection;

(3) The amount of MO HealthNet reimbursement for each DRG, including claims and pro

rata supplemental payments;

(4) The amount of Medicare reimbursement for each DRG.

A hospital shall not report or be required to report the information required by this subsection for any of the one hundred most frequently reported admissions where the reporting of such information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

11. Beginning with the quarter ending June 30, 2015, and quarterly thereafter, each participating hospital shall provide to the department, in a manner and format determined by the department, information on the total costs for the fifty most common outpatient surgical procedures by CPT code and the fifty most common imaging procedures by CPT code performed in hospital outpatient settings. Participating hospitals shall report this information in the same manner as required by subsection 10 of this section; provided that, hospitals shall not report or be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of HIPAA or other federal law.

12. The department shall promulgate rules to implement subsections 7 to 11 of this section, which shall include all of the following:

(1) The one hundred most frequently reported DRGs for inpatients for which participating hospitals will provide the data set out in subsection 10 of this section;

(2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the department's internet website;

(3) In accordance with subsection 11 of this section, the list of the fifty most common outpatient surgical procedures by CPT code and the fifty most common imaging procedures by CPT code performed in a hospital outpatient setting.

Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

191.1056. 1. There is hereby created in the state treasury the "Missouri Health Care Access Fund", which shall consist of gifts, grants, and devises deposited into the fund with approval of the **[**oversight committee created in section 208.955**]** joint committee on MO HealthNet created under section 208.952. The state treasurer shall be custodian of the fund and may disburse moneys from the fund in accordance with sections 30.170 and 30.180. Disbursements from the fund shall be subject to appropriations and the director shall approve disbursements from the fund consistent with such appropriations 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 health care services to the population in the facility's area of defined need.

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

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

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

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

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

197.170. 1. This section and section 197.173 shall be known as the "Health Care Cost Reduction and Transparency Act".

2. As used in this section and section 197.173 the following terms shall mean:

(1) "Ambulatory surgical center", a health care facility as such term is defined under section 197.200;

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

(3) "DRG", diagnosis related group;

(4) "Health carrier", an entity as such term is defined under section 376.1350;

(5) "Hospital", a health care facility as such term is defined under section 197.020;

(6) "Public or private third party", includes the state, the federal government, employers, health carriers, third-party administrators, and managed care organizations.

3. The department of health and senior services shall make available to the public on its internet website the most current price information it receives from hospitals and ambulatory surgical centers under section 197.173. The department shall provide this information in a manner that is easily understood by the public and meets the following minimum requirements:

(1) Information for each hospital shall be listed separately and hospitals shall be listed in groups by category as determined by the department in rules adopted pursuant to section 197.173;

(2) Information for each hospital outpatient department and each ambulatory surgical center shall be listed separately.

4. Any data disclosed to the department by a hospital or ambulatory surgical center under section 197.173 shall be the sole property of the hospital or center that submitted the data. Any data or product derived from the data disclosed pursuant to section 197.173, including a consolidation or analysis of the data, shall be the sole property of the state. The department shall not allow proprietary information it receives pursuant to section 197.173 to be used by any person or entity for commercial purposes.

197.173. 1. Beginning with the quarter ending June 30, 2015, and quarterly thereafter, each hospital shall provide to the department, utilizing electronic health records software, the following information about the one hundred most frequently reported admissions by DRG for inpatients as established by the department:

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges;

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection;

(3) The amount of MO HealthNet reimbursement for each DRG, including claims and pro rata supplemental payments;

(4) The amount of Medicare reimbursement for each DRG;

(5) For the five largest health carriers providing payment to the hospital on behalf of insureds and state employees, the range and the average of the amount of payment made for each DRG. Prior to providing this information to the department, each hospital shall redact the names of the health carrier and any other information that would otherwise identify the health carriers.

A hospital shall not be required to report the information required by this subsection for any of the one hundred most frequently reported admissions where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or other federal law.

2. Beginning with the quarter ending September 30, 2015, and quarterly thereafter, each hospital and ambulatory surgical center shall provide to the department, utilizing electronic health records software, information on the total costs for the twenty most common surgical procedures and the twenty most common imaging procedures, by volume, performed in hospital outpatient settings or in ambulatory surgical centers, along with the related current procedural terminology ("CPT") and healthcare common procedure coding system ("HCPCS") codes. Hospitals and ambulatory surgical centers shall report this information in the same manner as required by subsection 1 of this section, provided that hospitals and ambulatory surgical centers shall not be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of HIPAA or other federal law.

3. Upon request of a patient for a particular DRG, imaging procedure, or surgery procedure reported in this section, a hospital or ambulatory surgical center shall provide the information

required by subsection 1 or subsection 2 of this section to the patient in writing, either electronically or by mail, within three business days after receiving the request.

4. (1) The department shall promulgate rules on or before March 1, 2015, to ensure that subsection 1 of this section is properly implemented and that hospitals report this information to the department in a uniform manner. The rules shall include all of the following:

(a) The one hundred most frequently reported DRGs for inpatients for which hospitals must provide the data set out in subsection 1 of this section;

(b) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the department's internet website.

(2) The department shall promulgate rules on or before June 1, 2015, to ensure that subsection 2 of this section is properly implemented and that hospitals and ambulatory surgical centers report this information to the department in a uniform manner. The rules shall include the list of the twenty most common surgical procedures and the twenty most common imaging procedures, by volume, performed in a hospital outpatient setting and those performed in an ambulatory surgical facility, along with the related CPT and HCPCS codes.

(3) Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

197.305. As used in sections 197.300 to **[**197.366**]** 197.367, the following terms mean:

(1) "Affected persons", the person proposing the development of a new institutional health service, the public to be served, and health care facilities within **[**the service area in which**]** a five-mile radius of the proposed new health care service **[**is**]** to be developed;

(2) "Agency", the certificate of need program of the Missouri department of health and senior services;

(3) "Capital expenditure", an expenditure by or on behalf of a health care facility which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance;

(4) "Certificate of need", a written certificate issued by the committee setting forth the committee's affirmative finding that a proposed project sufficiently satisfies the criteria prescribed for such projects by sections 197.300 to **[**197.366**]** 197.367;

(5) "Develop", to undertake those activities which on their completion will result in the offering of a new institutional health service or the incurring of a financial obligation in relation to the offering of such a service;

(6) "Expenditure minimum" shall mean:

(a) For beds in existing or proposed health care facilities licensed pursuant to chapter 198 and long-term care beds in a hospital as described in subdivision (3) of subsection 1 of section 198.012, **[**six hundred thousand**]** one million dollars in the case of capital expenditures, or **[**four

hundred thousand**]** two million dollars in the case of major medical equipment, provided, however, that prior to January 1, 2003, the expenditure minimum for beds in such a facility and long-term care beds in a hospital described in section 198.012 shall be zero, subject to the provisions of subsection 7 of section 197.318;

(b) For beds or equipment in a long-term care hospital meeting the requirements described in 42 CFR, Section 412.23(e), the expenditure minimum shall be zero; and

(c) For health care facilities, new institutional health services or beds not described in paragraph (a) or (b) of this subdivision one million dollars in the case of capital expenditures, excluding major medical equipment, and one million dollars in the case of medical equipment;

(7) "Health service area", a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources, consisting of a population of not less than five hundred thousand or more than three million;

(8) "Major medical equipment", medical equipment used for the provision of medical and other health services;

(9) "New institutional health service":

(a) The development of a new health care facility costing in excess of the applicable expenditure minimum;

(b) The acquisition, including acquisition by lease, of any health care facility, or major medical equipment costing in excess of the expenditure minimum;

(c) Any capital expenditure by or on behalf of a health care facility in excess of the expenditure minimum;

(d) Predevelopment activities as defined in subdivision (12) **[**hereof**]** of this section costing in excess of one hundred fifty thousand dollars;

(e) Any change in licensed bed capacity of a health care facility which increases the total number of beds by more than ten or more than ten percent of total bed capacity, whichever is less, over a two-year period;

(f) Health services, excluding home health services, which are offered in a health care facility and which were not offered on a regular basis in such health care facility within the twelve-month period prior to the time such services would be offered;

(g) A reallocation by an existing health care facility of licensed beds among major types of service or reallocation of licensed beds from one physical facility or site to another by more than ten beds or more than ten percent of total licensed bed capacity, whichever is less, over a two-year period;

(10) "Nonsubstantive projects", projects which do not involve the addition, replacement, modernization or conversion of beds or the provision of a new health service but which include a capital expenditure which exceeds the expenditure minimum and are due to an act of God or a normal consequence of maintaining health care services, facility or equipment;

(11) "Person", any individual, trust, estate, partnership, corporation, including associations and joint stock companies, state or political subdivision or instrumentality thereof, including a municipal corporation;

(12) "Predevelopment activities", expenditures for architectural designs, plans, working drawings and specifications, and any arrangement or commitment made for financing; but excluding submission of an application for a certificate of need.

197.310. 1. The "Missouri Health Facilities Review Committee" is hereby established. The agency shall provide clerical and administrative support to the committee. The committee may employ additional staff as it deems necessary.

2. The committee shall be composed of:

(1) **[**Two members of the senate appointed by the president pro tem, who shall be from different political parties; and**]** One member who is professionally qualified in health insurance plan sales and administration;

(2) **[**Two members of the house of representatives appointed by the speaker, who shall be from different political parties; and**]** One member who has professionally qualified experience in commercial development, financing, and lending;

(3) **[**Five members**]** Two members with a doctorate of philosophy in economics;

(4) Two members who are professionally qualified as medical doctors or doctors of osteopathy, but who are not employees of a hospital or consultants to a hospital;

(5) Two members who are professionally experienced in hospital administration, but are not employed by a hospital or as consultants to a hospital; and

(6) One member who is a registered nurse, but who is not an employee of a hospital or a consultant to a hospital.

All members shall be appointed by the governor with the advice and consent of the senate, not more than **[**three**]** five of whom shall be from the same political party. All members shall serve four-year terms.

3. No business of this committee shall be performed without a majority of the full body.

4. **[**The members shall be appointed as soon as possible after September 28, 1979. One of the senate members, one of the house members and three of the members appointed by the governor shall serve until January 1, 1981, and the remaining members shall serve until January 1, 1982. All subsequent members shall be appointed in the manner provided in subsection 2 of this section and shall serve terms of two years.

5.**]** The committee shall elect a chairman at its first meeting which shall be called by the governor. The committee shall meet upon the call of the chairman or the governor.

[6.**]** 5. The committee shall review and approve or disapprove all applications for a certificate of need made under sections 197.300 to **[**197.366**]** 197.367. It shall issue reasonable rules and regulations governing the submission, review and disposition of applications.

[7.**]** 6. Members of the committee shall serve without compensation but shall be reimbursed for necessary expenses incurred in the performance of their duties.

[8.**]** 7. Notwithstanding the provisions of subsection 4 of section 610.025, the proceedings and records of the facilities review committee shall be subject to the provisions of chapter 610.

197.315. 1. Any person who proposes to develop or offer a new institutional health service within the state must obtain a certificate of need from the committee prior to the time such services

are offered. However, a certificate of need shall not be required for a proposed project which creates ten or more new full-time jobs, or full-time equivalent jobs provided that such person proposing the project submit a letter of intent and a report of the number of jobs and such other information as may be required by the health facilities review committee to document the basis for not requiring a certificate of need. If the letter of intent and report document that ten or more new full-time jobs or full-time equivalent jobs shall be created, the health facilities review committee shall respond within thirty days to such person with an approval of the non-applicability of a certificate of need. No job that was created prior to the approval of nonapplicability of a certificate of need shall be deemed a new job. For purposes of this subsection, a "full-time employee" means an employee of the person that is scheduled to work an average of at least thirty-five hours per week for a twelve-month period, and one for which the person offers health insurance and pays at least fifty-percent of such insurance premiums.

2. Only those new institutional health services which are found by the committee to be needed shall be granted a certificate of need. Only those new institutional health services which are granted certificates of need shall be offered or developed within the state. No expenditures for new institutional health services in excess of the applicable expenditure minimum shall be made by any person unless a certificate of need has been granted.

3. After October 1, 1980, no state agency charged by statute to license or certify health care facilities shall issue a license to or certify any such facility, or distinct part of such facility, that is developed without obtaining a certificate of need.

4. If any person proposes to develop any new institutional health care service without a certificate of need as required by sections 197.300 to **[**197.366**]** 197.367, the committee shall notify the attorney general, and he shall apply for an injunction or other appropriate legal action in any court of this state against that person.

5. After October 1, 1980, no agency of state government may appropriate or grant funds to or make payment of any funds to any person or health care facility which has not first obtained every certificate of need required pursuant to sections 197.300 to **[**197.366**]** 197.367.

6. A certificate of need shall be issued only for the premises and persons named in the application and is not transferable except by consent of the committee.

7. Project cost increases, due to changes in the project application as approved or due to project change orders, exceeding the initial estimate by more than ten percent shall not be incurred without consent of the committee.

8. Periodic reports to the committee shall be required of any applicant who has been granted a certificate of need until the project has been completed. The committee may order the forfeiture of the certificate of need upon failure of the applicant to file any such report.

9. A certificate of need shall be subject to forfeiture for failure to incur a capital expenditure on any approved project within six months after the date of the order. The applicant may request an extension from the committee of not more than six additional months based upon substantial expenditure made.

10. Each application for a certificate of need **[**must**]** shall be accompanied by an application fee. The time of filing commences with the receipt of the application and the application fee. The

application fee is one thousand dollars**[**, or one-tenth of one percent of the total cost of the proposed project, whichever is greater**]**. All application fees shall be deposited in the state treasury. Because of the loss of federal funds, the general assembly will appropriate funds to the Missouri health facilities review committee.

11. In determining whether a certificate of need should be granted, no consideration shall be given to the facilities or equipment of any other health care facility located more than a **[**fifteen-mile**]** five-mile radius from the applying facility.

12. When a nursing facility shifts from a skilled to an intermediate level of nursing care, it may return to the higher level of care if it meets the licensure requirements, without obtaining a certificate of need.

13. In no event shall a certificate of need be denied because the applicant refuses to provide abortion services or information.

14. A certificate of need shall not be required for the transfer of ownership of an existing and operational health facility in its entirety.

15. A certificate of need may be granted to a facility for an expansion, an addition of services, a new institutional service, or for a new hospital facility which provides for something less than that which was sought in the application.

16. The provisions of this section shall not apply to facilities operated by the state, and appropriation of funds to such facilities by the general assembly shall be deemed in compliance with this section, and such facilities shall be deemed to have received an appropriate certificate of need without payment of any fee or charge.

17. Notwithstanding other provisions of this section, a certificate of need may be issued after July 1, 1983, for an intermediate care facility operated exclusively for the **[**mentally retarded**]** intellectually disabled.

18. To assure the safe, appropriate, and cost-effective transfer of new medical technology throughout the state, a certificate of need shall not be required for the purchase and operation of research equipment that is to be used in a clinical trial that has received written approval from a duly constituted institutional review board of an accredited school of medicine or osteopathy located in Missouri to establish its safety and efficacy and does not increase the bed complement of the institution in which the equipment is to be located. After the clinical trial has been completed, a certificate of need must be obtained for continued use in such facility.

197.330. 1. The committee shall:

(1) Notify the applicant within fifteen days of the date of filing of an application as to the completeness of such application;

(2) Provide written notification to affected persons located within this state at the beginning of a review. This notification may be given through publication of the review schedule in all newspapers of general circulation in the area to be served;

(3) Hold public hearings on all applications when a request in writing is filed by any affected person within thirty days from the date of publication of the notification of review;

(4) Within one hundred days of the filing of any application for a certificate of need, issue in writing its findings of fact, conclusions of law, and its approval or denial of the certificate of need;

provided, that the committee may grant an extension of not more than thirty days on its own initiative or upon the written request of any affected person;

(5) Cause to be served upon the applicant, the respective health system agency, and any affected person who has filed his prior request in writing, a copy of the aforesaid findings, conclusions and decisions;

(6) Consider the needs and circumstances of institutions providing training programs for health personnel;

(7) Provide for the availability, based on demonstrated need, of both medical and osteopathic facilities and services to protect the freedom of patient choice; and

(8) Establish by regulation procedures to review, or grant a waiver from review, nonsubstantive projects. The term "filed" or "filing" as used in this section shall mean delivery to the staff of the health facilities review committee the document or documents the applicant believes constitute an application.

2. Failure by the committee to issue a written decision on an application for a certificate of need within the time required by this section shall constitute approval of and final administrative action on the application, and is subject to appeal pursuant to section 197.335 only on the question of approval by operation of law.

3. For all hearings held by the committee, including all public hearings under subdivision (3) of subsection 1 of this section:

(1) All testimony and other evidence taken during such hearings shall be under oath and subject to the penalty of perjury;

(2) The committee may, upon a majority vote of the committee, subpoena witnesses, and compel the attendance of witnesses, the giving of testimony, and the production of records;

(3) All ex parte communications between members of the committee and any interested party or witness which are related to the subject matter of a hearing shall be prohibited at any time prior to, during, or after such hearing;

(4) The provisions of sections 105.452 to 105.458, regarding conflict of interest shall apply;

(5) In all hearings, there shall be a rebuttable presumption of the need for additional medical services and lower costs for such medical services in the affected region or community. Any party opposing the issuance of a certificate of need shall have the burden of proof to show by clear and convincing evidence that no such need exists or that the new facility will cause a substantial and continuing loss of medical services within the affected region or community;

(6) All hearings before the committee shall be governed by rules to be adopted and prescribed by the committee; except that, in all inquiries or hearings, the committee shall not be bound by the technical rules of evidence. No formality in any proceeding nor in the manner of taking testimony before the committee shall invalidate any decision made by the committee; and

(7) The committee shall have the authority, upon a majority vote of the committee, to assess the costs of court reporting transcription or the issuance of subpoenas to one or both of the parties to the proceedings.

208.010. 1. In determining the eligibility of a claimant for public assistance pursuant to this law, it shall be the duty of the family support division to consider and take into account all facts and

circumstances surrounding the claimant, including his or her living conditions, earning capacity, income and resources, from whatever source received, and if from all the facts and circumstances the claimant is not found to be in need, assistance shall be denied. In determining the need of a claimant, the costs of providing medical treatment which may be furnished pursuant to sections 208.151 to 208.158 shall be disregarded. The amount of benefits, when added to all other income, resources, support, and maintenance shall provide such persons with reasonable subsistence compatible with decency and health in accordance with the standards developed by the family support division; provided, when a husband and wife are living together, the combined income and resources of both shall be considered in determining the eligibility of either or both. "Living together" for the purpose of this chapter is defined as including a husband and wife separated for the purpose of obtaining medical care or nursing home care, except that the income of a husband or wife separated for such purpose shall be considered in determining the eligibility of his or her spouse, only to the extent that such income exceeds the amount necessary to meet the needs (as defined by rule or regulation of the division) of such husband or wife living separately. In determining the need of a claimant in federally aided programs there shall be disregarded such amounts per month of earned income in making such determination as shall be required for federal participation by the provisions of the federal Social Security Act (42 U.S.C.A. 301, et seq.), or any amendments thereto. When federal law or regulations require the exemption of other income or resources, the family support division may provide by rule or regulation the amount of income or resources to be disregarded.

2. Benefits shall not be payable to any claimant who:

(1) Has or whose spouse with whom he or she is living has, prior to July 1, 1989, given away or sold a resource within the time and in the manner specified in this subdivision. In determining the resources of an individual, unless prohibited by federal statutes or regulations, there shall be included (but subject to the exclusions pursuant to subdivisions (4) and (5) of this subsection, and subsection 5 of this section) any resource or interest therein owned by such individual or spouse within the twenty-four months preceding the initial investigation, or at any time during which benefits are being drawn, if such individual or spouse gave away or sold such resource or interest within such period of time at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits, including but not limited to benefits based on December, 1973, eligibility requirements, as follows:

(a) Any transaction described in this subdivision shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance pursuant to this chapter unless such individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose;

(b) The resource shall be considered in determining eligibility from the date of the transfer for the number of months the uncompensated value of the disposed of resource is divisible by the average monthly grant paid or average Medicaid payment in the state at the time of the investigation to an individual or on his or her behalf under the program for which benefits are claimed, provided that:

a. When the uncompensated value is twelve thousand dollars or less, the resource shall not be used in determining eligibility for more than twenty-four months; or

b. When the uncompensated value exceeds twelve thousand dollars, the resource shall not be used in determining eligibility for more than sixty months;

(2) The provisions of subdivision (1) of this subsection shall not apply to a transfer, other than a transfer to claimant's spouse, made prior to March 26, 1981, when the claimant furnishes convincing evidence that the uncompensated value of the disposed of resource or any part thereof is no longer possessed or owned by the person to whom the resource was transferred;

(3) Has received, or whose spouse with whom he or she is living has received, benefits to which he or she was not entitled through misrepresentation or nondisclosure of material facts or failure to report any change in status or correct information with respect to property or income as required by section 208.210. A claimant ineligible pursuant to this subsection shall be ineligible for such period of time from the date of discovery as the family support division may deem proper; or in the case of overpayment of benefits, future benefits may be decreased, suspended or entirely withdrawn for such period of time as the division may deem proper;

(4) Owns or possesses resources in the sum of **[**one**]** two thousand dollars or more; provided, however, that if such person is married and living with spouse, he or she, or they, individually or jointly, may own resources not to exceed **[**two**]** four thousand dollars; and provided further, that in the case of a temporary assistance for needy families claimant, the provision of this subsection shall not apply;

(5) Prior to October 1, 1989, owns or possesses property of any kind or character, excluding amounts placed in an irrevocable prearranged funeral or burial contract under chapter 436, or has an interest in property, of which he or she is the record or beneficial owner, the value of such property, as determined by the family support division, less encumbrances of record, exceeds twenty-nine thousand dollars, or if married and actually living together with husband or wife, if the value of his or her property, or the value of his or her interest in property, together with that of such husband and wife, exceeds such amount;

(6) In the case of temporary assistance for needy families, if the parent, stepparent, and child or children in the home owns or possesses property of any kind or character, or has an interest in property for which he or she is a record or beneficial owner, the value of such property, as determined by the family support division and as allowed by federal law or regulation, less encumbrances of record, exceeds one thousand dollars, excluding the home occupied by the claimant, amounts placed in an irrevocable prearranged funeral or burial contract under chapter 436, one automobile which shall not exceed a value set forth by federal law or regulation and for a period not to exceed six months, such other real property which the family is making a good-faith effort to sell, if the family agrees in writing with the family support division to sell such property and from the net proceeds of the sale repay the amount of assistance received during such period. If the property has not been sold within six months, or if eligibility terminates for any other reason, the entire amount of assistance paid during such period shall be a debt due the state;

(7) Is an inmate of a public institution, except as a patient in a public medical institution.

3. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the income and resources of a relative or other person living in the home shall be taken into account to the extent the income, resources, support and maintenance are allowed by

federal law or regulation to be considered.

4. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the value of burial lots or any amounts placed in an irrevocable prearranged funeral or burial contract under chapter 436 shall not be taken into account or considered an asset of the burial lot owner or the beneficiary of an irrevocable prearranged funeral or funeral contract. For purposes of this section, "burial lots" means any burial space as defined in section 214.270 and any memorial, monument, marker, tombstone or letter marking a burial space. If the beneficiary, as defined in chapter 436, of an irrevocable prearranged funeral or burial contract receives any public assistance benefits pursuant to this chapter and if the purchaser of such contract or his or her successors in interest transfer, amend, or take any other such actions regarding the contract so that any person will be entitled to a refund, such refund shall be paid to the state of Missouri with any amount in excess of the public assistance benefits provided under this chapter to be refunded by the state of Missouri to the purchaser or his or her successors. In determining eligibility and the amount of benefits to be granted under federally aided programs, the value of any life insurance policy where a seller or provider is made the beneficiary or where the life insurance policy is assigned to a seller or provider, either being in consideration for an irrevocable prearranged funeral contract under chapter 436, shall not be taken into account or considered an asset of the beneficiary of the irrevocable prearranged funeral contract. In addition, the value of any funds, up to nine thousand nine hundred ninety-nine dollars, placed into an irrevocable personal funeral trust account, where the trustee of the irrevocable personal funeral trust account is a state or federally chartered financial institution authorized to exercise trust powers in the state of Missouri, shall not be taken into account or considered an asset of the person whose funds are so deposited if such funds are restricted to be used only for the burial, funeral, preparation of the body, or other final disposition of the person whose funds were deposited into said personal funeral trust account. No person or entity shall charge more than ten percent of the total amount deposited into a personal funeral trust in order to create or set up said personal funeral trust, and any fees charged for the maintenance of such a personal funeral trust shall not exceed three percent of the trust assets annually. Trustees may commingle funds from two or more such personal funeral trust accounts so long as accurate books and records are kept as to the value, deposits, and disbursements of each individual depositor's funds and trustees are to use the prudent investor standard as to the investment of any funds placed into a personal funeral trust. If the person whose funds are deposited into the personal funeral trust account receives any public assistance benefits pursuant to this chapter and any funds in the personal funeral trust account are, for any reason, not spent on the burial, funeral, preparation of the body, or other final disposition of the person whose funds were deposited into the trust account, such funds shall be paid to the state of Missouri with any amount in excess of the public assistance benefits provided under this chapter to be refunded by the state of Missouri to the person who received public assistance benefits or his or her successors. No contract with any cemetery, funeral establishment, or any provider or seller shall be required in regards to funds placed into a personal funeral trust account as set out in this subsection.

5. In determining the total property owned pursuant to subdivision (5) of subsection 2 of this section, or resources, of any person claiming or for whom public assistance is claimed, there shall be

disregarded any life insurance policy, or prearranged funeral or burial contract, or any two or more policies or contracts, or any combination of policies and contracts, which provides for the payment of one thousand five hundred dollars or less upon the death of any of the following:

(1) A claimant or person for whom benefits are claimed; or

(2) The spouse of a claimant or person for whom benefits are claimed with whom he or she is living.

If the value of such policies exceeds one thousand five hundred dollars, then the total value of such policies may be considered in determining resources; except that, in the case of temporary assistance for needy families, there shall be disregarded any prearranged funeral or burial contract, or any two or more contracts, which provides for the payment of one thousand five hundred dollars or less per family member.

6. Beginning September 30, 1989, when determining the eligibility of institutionalized spouses, as defined in 42 U.S.C. Section 1396r-5, for medical assistance benefits as provided for in section 208.151 and 42 U.S.C. Sections 1396a, et seq., the family support division shall comply with the provisions of the federal statutes and regulations. As necessary, the division shall by rule or regulation implement the federal law and regulations which shall include but not be limited to the establishment of income and resource standards and limitations. The division shall require:

(1) That at the beginning of a period of continuous institutionalization that is expected to last for thirty days or more, the institutionalized spouse, or the community spouse, may request an assessment by the family support division of total countable resources owned by either or both spouses;

(2) That the assessed resources of the institutionalized spouse and the community spouse may be allocated so that each receives an equal share;

(3) That upon an initial eligibility determination, if the community spouse's share does not equal at least twelve thousand dollars, the institutionalized spouse may transfer to the community spouse a resource allowance to increase the community spouse's share to twelve thousand dollars;

(4) That in the determination of initial eligibility of the institutionalized spouse, no resources attributed to the community spouse shall be used in determining the eligibility of the institutionalized spouse, except to the extent that the resources attributed to the community spouse do exceed the community spouse's resource allowance as defined in 42 U.S.C. Section 1396r-5;

(5) That beginning in January, 1990, the amount specified in subdivision (3) of this subsection shall be increased by the percentage increase in the Consumer Price Index for All Urban Consumers between September, 1988, and the September before the calendar year involved; and

(6) That beginning the month after initial eligibility for the institutionalized spouse is determined, the resources of the community spouse shall not be considered available to the institutionalized spouse during that continuous period of institutionalization.

7. Beginning July 1, 1989, institutionalized individuals shall be ineligible for the periods required and for the reasons specified in 42 U.S.C. Section 1396p.

8. The hearings required by 42 U.S.C. Section 1396r-5 shall be conducted pursuant to the provisions of section 208.080.

9. Beginning October 1, 1989, when determining eligibility for assistance pursuant to this chapter there shall be disregarded unless otherwise provided by federal or state statutes the home of the applicant or recipient when the home is providing shelter to the applicant or recipient, or his or her spouse or dependent child. The family support division shall establish by rule or regulation in conformance with applicable federal statutes and regulations a definition of the home and when the home shall be considered a resource that shall be considered in determining eligibility.

10. Reimbursement for services provided by an enrolled Medicaid provider to a recipient who is duly entitled to Title XIX Medicaid and Title XVIII Medicare Part B, Supplementary Medical Insurance (SMI) shall include payment in full of deductible and coinsurance amounts as determined due pursuant to the applicable provisions of federal regulations pertaining to Title XVIII Medicare Part B, except for hospital outpatient services or the applicable Title XIX cost sharing.

11. A "community spouse" is defined as being the noninstitutionalized spouse.

12. An institutionalized spouse applying for Medicaid and having a spouse living in the community shall be required, to the maximum extent permitted by law, to divert income to such community spouse to raise the community spouse's income to the level of the minimum monthly needs allowance, as described in 42 U.S.C. Section 1396r-5. Such diversion of income shall occur before the community spouse is allowed to retain assets in excess of the community spouse protected amount described in 42 U.S.C. Section 1396r-5.

208.018. 1. Subject to federal approval, the department of social services shall establish a pilot program for the purpose of providing Supplemental Nutrition Assistance Program (SNAP) participants with access and the ability to afford fresh food when purchasing fresh food at farmers' markets. The pilot program shall be established in at least one rural area and one urban area. Under the pilot program, such participants shall be able to:

(1) Purchase fresh fruit, vegetables, meat, fish, poultry, eggs, and honey with SNAP benefits with an electronic benefit transfer (EBT) card; and

(2) Receive a dollar-for-dollar match for every SNAP dollar spent at a participating farmers' market or vending urban agricultural zone as defined in section 262.900 in an amount up to ten dollars per week whenever the participant purchases fresh food with an EBT card.

2. For purposes of this section, the term "farmers' market" shall mean a market with multiple stalls at which farmer-producers sell agricultural products, particularly fresh fruit and vegetables, directly to the general public at a central or fixed location.

3. Purchases of approved fresh food by SNAP participants under this section shall automatically trigger matching funds reimbursement into the central vendor accounts by the department.

4. The funding of this pilot program shall be subject to appropriation. In addition to appropriations from the general assembly, the department may apply for available grants and shall be able to accept other gifts, grants, and donations to develop and maintain the program.

5. The department shall promulgate rules setting forth the procedures and methods of implementing this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This

section and chapter 536 are nonseverable and if any of the powers vested with the general assembly under chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

6. Under section 23.253 of the Missouri sunset act:

(1) The provisions of this section shall sunset automatically six years after the effective date of this section unless reauthorized by an act of the general assembly; and

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

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

208.023. 1. Subject to federal approval, the department of social services shall:

(1) Mandate the use of photo identification for continued eligibility in the Supplemental Nutrition Assistance Program (SNAP) administered in Missouri. Upon one year after approval by the federal government, all electronic benefit cards distributed to recipients of SNAP shall have imprinted on the card a photograph of the recipient or protective payee authorized to use the card and shall expire and be subject to renewal after a period of three years. The card shall not be accepted for use by a retail establishment if the photograph of the recipient does not match the person presenting the card;

(2) Require all SNAP applicants to sign an affidavit stating that he or she shall provide sufficient information of job status and availability, accept suitable employment if offered, continue employment once hired, and shall not voluntarily reduce employment hours. Failure to comply with the provisions of this subsection may result in loss of SNAP benefits;

(3) Require all SNAP recipients to participate in either one or a combination of conditions of eligibility as applicable to the recipient such as obtaining further education, employment search, clubs or readiness programs, community service, employment training, or employment;

(4) Require SNAP recipients to report to the department if his or her monthly income rises above the maximum allowed for the applicable household size; and

(5) Require SNAP recipients to complete a verification process once every twelve months.

2. The department of social services shall promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

208.024. 1. Eligible recipients of temporary assistance for needy families (TANF) benefits shall not use such funds in any electronic benefit transfer transaction for the purchase of alcoholic beverages, lottery tickets, or tobacco products in any liquor store, casino, gambling casino, or gaming establishment, or any retail establishment which provides adult-oriented entertainment in

which performers disrobe or perform in an unclothed state for entertainment**[**, or in any place or for any item that is primarily marketed for or used by adults eighteen or older and/or is not in the best interests of the child or household**]**. An eligible recipient of TANF assistance who makes a purchase in violation of this section shall reimburse the department of social services for such purchase.

2. An individual, store owner or proprietor of an establishment shall not accept TANF cash assistance funds held on electronic benefit transfer cards for the purchase of alcoholic beverages, lottery tickets, or tobacco products or for use in any electronic benefit transfer transaction in any liquor store, casino, gambling casino, or gaming establishment, or any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment**[**, or in any place or for any item that is primarily marketed for or used by adults eighteen or older and/or is not in the best interests of the child or household**]**. No store owner or proprietor of any liquor store, casino, gambling casino, or gaming establishment, or any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment shall adopt any policy, either explicitly or implicitly, which encourages, permits, or acquiesces in its employees knowingly accepting electronic benefit transfer cards in violation of this section. An individual, store owner or proprietor of an establishment who knowingly accepts electronic benefit transfer cards in violation of this section shall be punished by a fine of not more than five hundred dollars for the first offense, a fine of not less than five hundred dollars nor more than one thousand dollars for the second offense, and a fine of not less than one thousand dollars for the third or subsequent offense.

3. Any recipient of TANF benefits who does not make at least one electronic benefit transfer transaction within the state for a period of ninety days shall have his or her benefit payments to the electronic benefit account temporarily suspended, pending an investigation by the department of social services to determine if the recipient is no longer a Missouri resident. If the department finds that the recipient is no longer a Missouri resident, it shall close the recipient's case. Closure of a recipient's case shall trigger the automated benefit eligibility process under section 208.238. To ensure that the case is not erroneously closed, a recipient shall be allowed an appeal to the director under section 208.080.

4. A recipient who does not make an electronic benefit transfer transaction within the state for a period of sixty days shall be provided notice of the possibility of the suspension of funds if no electronic benefit transfer transaction occurs in the state within another thirty days after the date of the notice.

5. For purposes of this section:

(1) The following terms shall mean:

(a) "Electronic benefit transfer transaction", the use of a credit or debit card service, automated teller machine, point-of-sale terminal, or access to an online system for the withdrawal of funds or the processing of a payment for merchandise or a service; and

(b) "Liquor store", any retail establishment which sells exclusively or primarily intoxicating liquor. Such term does not include a grocery store which sells both intoxicating liquor and groceries including staple foods as outlined under the Food and Nutrition Act of 2008;

(2) Casinos, gambling casinos, or gaming establishments shall not include:

(a) A grocery store which sells groceries including staple foods, and which also offers, or is located within the same building or complex as a casino, gambling, or gaming activities; or

(b) Any other establishment that offers casino, gambling, or gaming activities incidental to the principal purpose of the business.

208.027. 1. The department of social services shall develop a program to screen each applicant or recipient who is otherwise eligible for temporary assistance for needy families benefits under this chapter, and then test, using a urine dipstick five panel test, each one who the department has reasonable cause to believe, based on the screening, engages in illegal use of controlled substances. Any applicant or recipient who is found to have tested positive for the use of a controlled substance, which was not prescribed for such applicant or recipient by a licensed health care provider, or who refuses to submit to a test, shall**[**, after an administrative hearing conducted by the department under the provisions of chapter 536,**]** be declared ineligible for temporary assistance for needy families benefits for a period of three years from the date of the positive test, test refusal, or administrative hearing decision, if requested by the applicant or recipient under subsection 2 of this section, unless such applicant or recipient, after having been referred by the department, enters and successfully completes a substance abuse treatment program and does not test positive for illegal use of a controlled substance in the six-month period beginning on the date of entry into such rehabilitation or treatment program. The applicant or recipient shall continue to receive benefits while participating in the treatment program. The department may test the applicant or recipient for illegal drug use at random or set intervals, at the department's discretion, after such period. If the applicant or recipient tests positive for the use of illegal drugs a second time, then such applicant or recipient shall be declared ineligible for temporary assistance for needy families benefits for a period of three years from the date of the positive test, test refusal, or administrative hearing decision, if requested by the applicant or recipient under subsection 2 of this section. The department shall refer an applicant or recipient who tested positive for the use of a controlled substance under this section to an appropriate substance abuse treatment program approved by the division of alcohol and drug abuse within the department of mental health.

2. An applicant or recipient who is found to have tested positive or who refuses to submit to a test under subsection 1 of this section may request that an administrative hearing be conducted under the provisions of section 208.080.

3. Case workers of applicants or recipients shall be required to report or cause a report to be made to the children's division in accordance with the provisions of sections 210.109 to 210.183 for suspected child abuse as a result of drug abuse in instances where the case worker has knowledge that:

(1) An applicant or recipient has tested positive for the illegal use of a controlled substance; or

(2) An applicant or recipient has refused to be tested for the illegal use of a controlled substance.

[3.**]** 4. Other members of a household which includes a person who has been declared ineligible for temporary assistance for needy families assistance shall, if otherwise eligible, continue to receive temporary assistance for needy families benefits as protective or vendor payments to a

third-party payee for the benefit of the members of the household.

[4.**]** 5. The department of social services shall promulgate rules to develop the screening and testing provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, **[**2011**]** 2014, shall be invalid and void.

208.031. 1. Electronic benefit transfer transactions made by each applicant or recipient who is otherwise eligible for temporary assistance for needy families benefits under this chapter and who is found to have made a cash withdrawal at any casino, gambling casino, or gaming establishment shall be declared ineligible for temporary assistance for needy families benefits for a period of three years from the date of mailing of the notice of proposed action to declare the applicant or recipient ineligible for a period of three years. The applicant or recipient may request an administrative hearing be conducted by the department under the provisions of section 208.080 to contest the proposed action. For purposes of this section, "casino, gambling casino, or gaming establishment" does not include a grocery store which sells groceries including staple foods and which also offers, or is located within the same building or complex as casino, gambling, or gaming activities.

2. Other members of a household which includes a person who has been declared ineligible for temporary assistance for needy families assistance shall, if otherwise eligible, continue to receive temporary assistance for needy families benefits as protective or vendor payments to a third-party payee for the benefit of the members of the household.

3. Any person who, in good faith, reports a suspected violation of this section by a temporary assistance for needy families (TANF) recipient shall not be held civilly or criminally liable for reporting such suspected violation.

4. The department of social services shall promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly under chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

208.080. 1. Any applicant for or recipient of benefits or services provided by law by the division of family services may appeal to the director of the division of family services from a decision of a county office of the division of family services in any of the following cases:

(1) If his right to make application for any such benefits or services is denied; or

(2) If his application is disallowed in whole or in part, or is not acted upon within a reasonable time after it is filed; or

(3) If it is proposed to cancel or modify benefits or services; or

(4) If he is adversely affected by any determination of a county office of the division of family services in its administration of the programs administered by it; or

(5) If a determination is made pursuant to subsection 2 of section 208.180 that payment of benefits on behalf of a dependent child shall not be made to the relative with whom he lives.

2. If the division proposes to terminate or modify the payment of benefits or the providing of services to the recipient or the division has terminated or modified the payment of benefits or providing of services to the recipient and the recipient appeals, the decision of the director as to the eligibility of the recipient at the time such action was proposed or taken shall be based on the facts shown by the evidence presented at the hearing of the appeal to have existed at the time such action to terminate or modify was proposed or was taken.

3. In the case of a proposed action by the county office of the division of family services to reduce, modify, or discontinue benefits or services to a recipient, the recipient of such benefits or services shall have ten days from the date of the mailing of notice of the proposed action to reduce, modify, or discontinue benefits or services within which to request an appeal to the director of the division of family services. In the notice to the recipient of such proposed action, the county office of the division of family services shall notify the recipient of all his rights of appeal under this section. Proper blank forms for appeal to the director of the division of family services shall be furnished by the county office to any aggrieved recipient. Every such appeal to the director of the division of family services shall be transmitted by the county office to the director of the division of family services immediately upon the same being filed with the county office. If an appeal is requested, benefits or services shall continue undiminished or unchanged until such appeal is heard and a decision has been rendered thereon, except that in an aid to families with dependent children case the recipient may request that benefits or services not be continued undiminished or unchanged during the appeal.

4. When a case has been closed or modified and no appeal was requested prior to closing or modification, the recipient shall have ninety days from the date of closing or modification to request an appeal to the director of the **[**division of family services**]** family support division. Each recipient **[**who has not requested an appeal prior to the closing or modification of his case**]** shall be notified **[**at the time of such closing or modification**]** before adverse action is taken of his right to request an appeal during this ninety-day period. Proper blank forms for requesting an appeal to the director of the **[**division of family services**]** family support division shall be furnished by the **[**county office**]** family support division to any aggrieved applicant. Every such request made in any manner for an appeal to the director of the **[**division of family services**]** family support division shall be transmitted by the **[**county office**]** family support division to the director of the **[**division of family services**]** family support division immediately upon the same being filed with the **[**county office**]** family support division. If an appeal is requested in the ninety-day period subsequent to the closing or modification, benefits or services shall not be continued at their prior level during the pendency of the appeal.

5. In the case of a rejection of an application for benefits or services, the aggrieved applicant shall have ninety days from the date of the notice of the action in which to request an appeal to the director of the division of family services. In the rejection notice the applicant for benefits or

services shall be notified of all of his rights of appeal under this section. Proper blank forms for requesting an appeal to the director of the division of family services shall be furnished by the county office to any aggrieved applicant. Any such request made in any manner for an appeal shall be transmitted by the county office to the director of the division of family services, immediately upon the same being filed with the county office.

6. If the division has rejected an application for benefits or services and the applicant appeals, the decision of the director as to the eligibility of the applicant at the time such rejection was made shall be based upon the facts shown by the evidence presented at the hearing of the appeal to have existed at the time the rejection was made.

7. The director of the division of family services shall give the applicant for benefits or services or the recipient of benefits or services reasonable notice of, and an opportunity for, a fair hearing in the county of his residence at the time the adverse action was taken. The hearing shall be conducted by the director of the division of family services or his designee.

Every applicant or recipient, on appeal to the director of the division of family services, shall be entitled to be present at the hearing, in person and by attorney or representative, and shall be entitled to introduce into the record of such hearing any and all evidence, by witnesses or otherwise, pertinent to such applicant's or recipient's eligibility between the time he applied for benefits or services and the time the application was denied or the benefits or services were terminated or modified, and all such evidence shall be taken down, preserved, and shall become a part of the applicant's or recipient's appeal record. Upon the record so made, the director of the division of family services shall determine all questions presented by the appeal, and shall make such decision as to the granting of benefits or services as in his opinion is justified and is in conformity with the provisions of the law. The director shall clearly state the reasons for his decision and shall include a statement of findings of fact and conclusions of law pertinent to the questions in issue.

8. All appeal requests may initially be made orally or in any written form, but all such requests shall be transcribed on forms furnished by the division of family services and signed by the aggrieved applicant or recipient or his representative prior to the commencement of the hearing.

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

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

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

(3) All participants receiving blind pension benefits;

(4) All persons who would be determined to be eligible for old age assistance benefits,

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

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

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

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

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

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

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

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

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

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

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of age, the family support division shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency. As necessary to provide MO HealthNet coverage under this subdivision, the department of social services may revise the state MO HealthNet plan to extend coverage under 42 U.S.C. 1396a (a)(10)(A)(i)(III) to

children who have attained six years of age but have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42 U.S.C. 1396a;

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

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

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

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

(19) Subject to appropriations necessary to recruit and train such staff, the family support division shall provide one or more full-time, permanent eligibility specialists to process applications for MO HealthNet benefits at the site of a health care provider, if the health care provider requests the placement of such eligibility specialists and reimburses the division for the expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment of such eligibility specialists. The division may provide a health care provider with a part-time or temporary eligibility specialist at the site of a health care provider if the health care provider requests the placement of such an eligibility specialist and reimburses the division for the expenses, including but not limited to the salary, benefits, travel, training, telephone, supplies, and equipment, of such an

eligibility specialist. The division may seek to employ such eligibility specialists who are otherwise qualified for such positions and who are current or former welfare participants. The division may consider training such current or former welfare participants as eligibility specialists for this program;

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

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

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

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

(24) (a) All persons who would be determined to be eligible for old age assistance benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriation;

(b) All persons who would be determined to be eligible for aid to the blind benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005, except that less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal poverty level;

(c) All persons who would be determined to be eligible for permanent and total disability benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. 1396a(f); or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriations. Eligibility standards for permanent and total disability benefits shall not be limited by age;

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

(26) Effective August 28, 2013, persons who are in foster care under the responsibility of the state of Missouri on the date such persons attain the age of eighteen years, or at any time during the thirty-day period preceding their eighteenth birthday, without regard to income or assets, if such persons:

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

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

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

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

3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for MO HealthNet benefits for four calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for MO HealthNet benefits for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C.

1396r-6. Each family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. 1396r-6 shall receive MO HealthNet benefits without fee for an additional six months. The MO HealthNet division may provide by rule and as authorized by annual appropriation the scope of MO HealthNet coverage to be granted to such families.

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

5. The department of social services may apply to the federal Department of Health and Human Services for a MO HealthNet waiver amendment to the Section 1115 demonstration waiver or for any additional MO HealthNet waivers necessary not to exceed one million dollars in additional costs to the state, unless subject to appropriation or directed by statute, but in no event shall such waiver applications or amendments seek to waive the services of a rural health clinic or a federally qualified health center as defined in 42 U.S.C. 1396d(l)(1) and (2) or the payment requirements for such clinics and centers as provided in 42 U.S.C. 1396a(a)(15) and 1396a(bb) unless such waiver application is approved by the **[**oversight committee created in section 208.955**]** joint committee on MO HealthNet created under section 208.952. A request for such a waiver so submitted shall only become effective by executive order not sooner than ninety days after the final adjournment of the session of the general assembly to which it is submitted, unless it is disapproved within sixty days of its submission to a regular session by a senate or house resolution adopted by a majority vote of the respective elected members thereof, unless the request for such a waiver is made subject to appropriation or directed by statute.

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

7. The department of social services shall notify any potential exchange-eligible participant who may be eligible for services due to spenddown that the participant may qualify for more cost-effective private insurance and premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended, available through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis and the benefits that would be potentially covered under such insurance.

208.238. Subject to appropriations, the department of social services shall implement an automated process to ensure applicants applying for benefit programs are eligible for such programs. The automated process shall be designed to periodically review current beneficiaries to ensure that they remain eligible for benefits they are receiving. The system shall check applicant and recipient information against multiple sources of information through an automated process. If the automated process shows the recipient is no longer eligible for one benefit program, the department shall

determine what other benefit programs shall be closed to the recipient.

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

(1) "Department", the department of social services;

(2) "Fraud", a known false representation, including the concealment of a material fact, upon which the recipient claims eligibility for public assistance benefits;

(3) "Public assistance benefits", temporary assistance for needy families benefits, food stamps, medical assistance, or other similar assistance administered by the department of social services or other state department;

(4) "Recipient", a person who is eligible to receive public assistance benefits.

2. The department shall apply for all appropriate waivers and state plan amendments and, subject to the receipt of said waivers and approval of state plan amendments, the department shall permanently make ineligible for public assistance benefits any person who knowingly and intentionally commits fraud in obtaining or attempting to obtain public assistance benefits.

3. Any persons who, based upon their personal knowledge, have reasonable cause to believe an act of public assistance benefits fraud is being committed shall report such act to the department. When a report of suspected public assistance benefits fraud is received by the department, the department shall investigate such report. An investigation of public assistance benefits fraud shall be initiated by the department within fifteen days of receipt of the report. Absent good cause, any investigation shall be concluded within sixty days of receipt of the report. The burden of conducting the investigation rests with the fraud investigator or fraud unit and not the recipient's caseworker. Failure to comply with the provisions of this section shall be grounds for termination of employment. The investigation must include:

(1) A request for the employment records and pay stubs of the recipient covering the previous six months;

(2) Verification of all individuals living in the household of the recipient;

(3) A copy of any rental agreement for the residence or a copy of the deed of the home;

(4) A copy of any court order regarding custody of any minor children living in the home; and

(5) The state and federal tax returns of the recipient for the previous two years."; and

Further amend said bill, Page 4, Section 208.646, Line 8, by inserting after all of said section and line the following:

"208.647. Any child identified as having "special health care needs", defined as a condition which left untreated would result in the death or serious physical injury of a child, that does not have access to affordable employer-subsidized health care insurance shall not be required to be without health care coverage for six months in order to be eligible for services under sections 208.631 to **[**208.657**]** 208.658 and shall not be subject to the waiting period required under section 208.646, as long as the child meets all other qualifications for eligibility.

208.650. 1. The department of social services shall commission a study on the impact of this program on providing a comprehensive array of community-based wraparound services for seriously

emotionally disturbed children and children affected by substance abuse. The department shall issue a report to the general assembly within forty-five days of the twelve-month anniversary of the beginning of this program and yearly thereafter. This report shall include recommendations to the department on how to improve access to the provisions of community-based wraparound services pursuant to sections 208.631 to **[**208.660**]** 208.658.

2. The department of social services shall prepare an annual report to the governor and the general assembly on the effect of this program. The report shall include, but is not limited to:

(1) The number of children participating in the program in each income category;

(2) The effect of the program on the number of children covered by private insurers;

(3) The effect of the program on medical facilities, particularly emergency rooms;

(4) The overall effect of the program on the health care of Missouri residents;

(5) The overall cost of the program to the state of Missouri; and

(6) The methodology used to determine availability for the purpose of enrollment, as established by rule.

3. The department of social services shall establish an identification program to identify children not participating in the program though eligible for extended medical coverage. The department's efforts to identify these uninsured children shall include, but not be limited to:

(1) Working closely with hospitals and other medical facilities; and

(2) Establishing a statewide education and information program.

4. The department of social services shall commission a study on any negative impact this program may have on the number of children covered by private insurance as a result of expanding health care coverage to children with a gross family income above one hundred eighty-five percent of the federal poverty level. The department shall issue a report to the general assembly within forty-five days of the twelve-month anniversary of the beginning of this program and annually thereafter. If this study demonstrates that a measurable negative impact on the number of privately insured children is occurring, the department shall take one or more of the following measures targeted at eliminating the negative impact:

(1) Implementing additional co-payments, sliding scale premiums or other cost-sharing provisions;

(2) Adding an insurability test to preclude participation;

(3) Increasing the length of the required period of uninsured status prior to application;

(4) Limiting enrollment to an annual open enrollment period for children with gross family incomes above one hundred eighty-five percent of the federal poverty level; and

(5) Any other measures designed to efficiently respond to the measurable negative impact.

208.655. No funds used to pay for insurance or for services pursuant to sections 208.631 to **[**208.657**]** 208.658 may be expended to encourage, counsel or refer for abortion unless the abortion is done to save the life of the mother or if the unborn child is the result of rape or incest. No funds may be paid pursuant to sections 208.631 to **[**208.657**]** 208.658 to any person or organization that performs abortions or counsels or refers for abortion unless the abortion is done to save the life of the mother or if the unborn child is the result of rape or incest.

208.657. Any rule or portion of a rule, as that term is defined in section 536.010, that is

promulgated under the authority delegated in this chapter shall become effective only if the agency has fully complied with all of the requirements of chapter 536, including but not limited to, section 536.028, if applicable, after August 28, 1998. All rulemaking authority delegated prior to August 28, 1998, is of no force and effect and repealed as of August 28, 1998, however, nothing in sections 208.631 to **[**208.657**]** 208.658 shall be interpreted to repeal or affect the validity of any rule adopted or promulgated prior to August 28, 1998. If the provisions of section 536.028, apply, the provisions of sections 208.631 to **[**208.657**]** 208.658 are nonseverable and if any of the powers vested with the general assembly pursuant to section 536.028 to review, to delay the effective date, or to disapprove and annul a rule or portion of a rule are held unconstitutional or invalid, the purported grant of rulemaking authority and any rule so proposed and contained in the order of rulemaking shall be invalid and void, except that nothing in sections 208.631 to **[**208.660**]** 208.658 shall affect the validity of any rule adopted and promulgated prior to August 28, 1998.

208.658. 1. For each school year beginning July 1, 2010, the department of social services shall provide all state licensed child-care providers who receive state or federal funds under section 210.027 and all public school districts in this state with written information regarding eligibility criteria and application procedures for the state children's health insurance program (SCHIP) authorized in sections 208.631 to **[**208.657**]** 208.658, to be distributed by the child-care providers or school districts to parents and guardians at the time of enrollment of their children in child care or school, as applicable.

2. The department of elementary and secondary education shall add an attachment to the application for the free and reduced lunch program for a parent or guardian to check a box indicating yes or no whether each child in the family has health care insurance. If any such child does not have health care insurance, and the parent or guardian's household income does not exceed the highest income level under 42 U.S.C. Section 1397CC, as amended, the school district shall provide a notice to such parent or guardian that the uninsured child may qualify for health insurance under SCHIP.

3. The notice described in subsection 2 shall be developed by the department of social services and shall include information on enrolling the child in the program. No notices relating to the state children's health insurance program shall be provided to a parent or guardian under this section other than the notices developed by the department of social services under this section.

4. Notwithstanding any other provision of law to the contrary, no penalty shall be assessed upon any parent or guardian who fails to provide or provides any inaccurate information required under this section.

5. The department of elementary and secondary education and the department of social services may adopt rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2010, shall be invalid and void.

6. The department of elementary and secondary education, in collaboration with the department of social services, shall report annually to the governor and the house budget committee chair and the senate appropriations committee chair on the following:

(1) The number of families in each district receiving free lunch and reduced lunches;

(2) The number of families who indicate the absence of health care insurance on the application for free and reduced lunches;

(3) The number of families who received information on the state children's health insurance program under this section; and

(4) The number of families who received the information in subdivision (3) of this subsection and applied to the state children's health insurance program.

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

2. Beginning July 1, 2015, the provisions of subsection 1 of this section shall no longer be in effect. Such change in eligibility shall not take place unless and until:

(1) For a six-month period preceding the discontinuance of benefits under this subsection there are health insurance premium tax credits available for children and family coverage under Section 36B of the Internal Revenue Code of 1986, as amended, available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis, which have been in place for a six-month period; and

(2) The provisions of subsection 4 of section 208.991 have been approved by the federal Department of Health and Human Services, and have been implemented by the department.

208.662. 1. There is hereby established within the department of social services the "Show-Me Healthy Babies Program" as a separate children's health insurance program (CHIP) for any low-income unborn child. The program shall be established under the authority of Title XXI of the federal Social Security Act, the State Children's Health Insurance Program, as amended, and 42 CFR 457.1.

2. For an unborn child to be enrolled in the show-me healthy babies program, his or her mother shall not be eligible for coverage under Title XIX of the federal Social Security Act, the Medicaid program as it is administered by the state, and shall not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. In addition, the unborn child shall be in a family with income eligibility of no more than three hundred percent of the federal poverty level, or the equivalent modified adjusted gross income, unless the income eligibility is set lower by the general assembly through appropriations. In calculating family size as it relates to income eligibility, the family shall include, in addition to other family members, all unborn children.

3. Coverage for an unborn child enrolled in the show-me healthy babies program shall

include all prenatal care and pregnancy-related services that benefit the health of the unborn child and that promote healthy labor, delivery, and birth. Coverage need not include services that are solely for the benefit of the pregnant mother, that are unrelated to maintaining or promoting a healthy pregnancy, or that provide no benefit to the unborn child. However, the department may include pregnancy-related assistance as defined in 42 U.S.C. Section 1397ll.

4. There shall be no waiting period before an unborn child may be enrolled in the show-me healthy babies program. In accordance with the definition of child in 42 CFR 457.10, coverage shall include the period from conception to birth. The department shall develop a presumptive eligibility procedure for enrolling an unborn child, which shall include verification of the pregnancy.

5. Coverage for the child shall continue for up to one year after birth, unless otherwise prohibited by law or limited by the general assembly through appropriations.

6. Pregnancy-related and postpartum coverage for the mother shall begin on the day the pregnancy ends and extend through the last day of the month that includes the sixtieth day after the pregnancy ends, unless otherwise prohibited by law or limited by the general assembly through appropriations. The department may include pregnancy-related assistance as defined in 42 U.S.C. 1397ll.

7. The department shall provide coverage for an unborn child enrolled in the show-me healthy babies program in the same manner in which the department provides coverage for the children's health insurance program in the county of the primary residence of the mother.

8. The department shall provide information about the show-me healthy babies program to maternity homes as defined in section 135.600, pregnancy resource centers as defined in section 135.630, and other similar agencies and programs in the state that assist unborn children and their mothers. The department shall consider allowing such agencies and programs to assist in the enrollment of unborn children in the program and in making determinations about presumptive eligibility and verification of the pregnancy.

9. Within sixty days after the effective date of this section, the department shall submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the show-me healthy babies program. This section shall be null and void unless and until the state plan amendments and waivers necessary to implement this section have been approved by the federal Department of Health and Human Services.

10. At least annually, the department shall prepare and submit a report to the governor, the speaker of the house of representatives, and the president pro tempore of the senate analyzing and projecting the cost savings and benefits, if any, to the state, counties, local communities, school districts, law enforcement agencies, correctional centers, health care providers, employers, other public and private entities, and persons by enrolling unborn children in the show-me healthy babies program. The analysis and projection of cost savings and benefits, if any, may include but need not be limited to:

(1) The higher federal matching rate for having an unborn child enrolled in the show-me healthy babies program versus the lower federal matching rate for a pregnant woman being enrolled in MO HealthNet or other federal programs;

(2) The change in the proportion of unborn children who receive care in the first trimester of

pregnancy due to a lack of waiting periods, by allowing presumptive eligibility, or by removal of other barriers, and any resulting or projected decrease in health problems and other problems for unborn children and women throughout pregnancy; at labor, delivery, and birth; and during infancy and childhood;

(3) The change in healthy behaviors by pregnant women, such as the cessation of the use of tobacco, alcohol, illicit drugs, or other harmful practices, and any resulting or projected short-term and long-term decrease in birth defects; poor motor skills; vision, speech, and hearing problems; breathing and respiratory problems; feeding and digestive problems; and other physical, mental, educational, and behavioral problems; and

(4) The change in infant and maternal mortality, pre-term births and low birth weight babies, and any resulting or projected decrease in short-term and long-term medical and other interventions.

11. The show-me healthy babies program shall not be deemed an entitlement program, but instead shall be subject to a federal allotment or other federal appropriations and matching state appropriations.

12. Nothing in this section shall be construed as obligating the state to continue the show-me healthy babies program if the allotment or payments from the federal government end, are not sufficient for the program to operate, or if the general assembly does not appropriate funds for the program.

13. Nothing in this section shall be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government on the state.

208.670. 1. As used in this section, these terms shall have the following meaning:

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

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

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

3. Telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. Reimbursement for such services shall be made in the same way as reimbursement for in-person contacts;

4. In addition to the subjects to be promulgated under subsection 2 of this section, the rules shall set requirements for the use of:

(1) Out-of-state health care providers enrolled as MO HealthNet providers to use MO HealthNet telehealth services in collaboration with a licensed Missouri health care provider in order to address provider shortage in a geographic area; and

(2) Specialists, including hospitalists, to monitor patients through telehealth services in small and rural or community hospitals.

208.950. 1. The department of social services shall**[**, with the advice and approval of the Mo HealthNet oversight committee established under section 208.955,**]** create health improvement plans for all participants in Mo HealthNet. Such health improvement plans shall include but not be limited to, risk-bearing coordinated care plans, administrative services organizations, and coordinated fee-for-service plans. Development of the plans and enrollment into such plans shall begin July 1, 2008, and shall be completed by July 1, 2011, and shall take into account the appropriateness of enrolling particular participants into the specific plans and the time line for enrollment. For risk-bearing care coordination plans and administrative services organization plans, the contract shall require that the contracted per diem be reduced or other financial penalty occur if the quality targets specified by the department are not met. For purposes of this section, "quality targets specified by the department" shall include, but not be limited to, rates at which participants whose care is being managed by such plans seek to use hospital emergency department services for nonemergency medical conditions.

2. Every participant shall be enrolled in a health improvement plan and be provided a health care home. All health improvement plans are required to help participants remain in the least restrictive level of care possible, use domestic-based call centers and nurse help lines, and report on participant and provider satisfaction information annually. All health improvement plans shall use best practices that are evidence-based. The department of social services shall evaluate and compare all health improvement plans on the basis of cost, quality, health improvement, health outcomes, social and behavioral outcomes, health status, customer satisfaction, use of evidence-based medicine, and use of best practices**[** and shall report such findings to the oversight committee**]**.

3. When creating a health improvement plan for participants, the department shall ensure that the rules and policies are promulgated consistent with the principles of transparency, personal responsibility, prevention and wellness, performance-based assessments, and achievement of improved health outcomes, increasing access, and cost-effective delivery through the use of technology and coordination of care.

4. No provisions of any state law shall be construed as to require any aged, blind, or disabled person to enroll in a risk-bearing coordination plan.

5. The department of social services shall, by July 1, 2008, commission an independent survey to assess health and wellness outcomes of MO HealthNet participants by examining key health care delivery system indicators, including but not limited to disease-specific outcome measures, provider network demographic statistics including but not limited to the number of providers per unit population broken down by specialty, subspecialty, and multidisciplinary providers by geographic areas of the state in comparison side-by-side with like indicators of providers available to the state-wide population, and participant and provider program satisfaction surveys. In counting the number of providers available, the study design shall use a definition of provider availability such that a provider that limits the number of MO HealthNet recipients seen in a unit of time is counted as a partial provider in the determination of availability. The 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**[**,**]** and the governor**[**, and the oversight committee**]**.

6. 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.

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

8. For any necessary contracts related to the purchase of products or services required to administer the MO HealthNet program, there shall be competitive requests for proposals consistent with state procurement policies of chapter 34 or through other existing state procurement processes specified in chapter 630.

208.952. 1. There is hereby established **[**the**]** a permanent "Joint Committee on MO HealthNet". The committee shall have as its purpose the study, monitoring, and review of the efficacy of the program as well as the resources needed to continue and improve the MO HealthNet program over time. The committee shall receive and obtain information from the departments of social services, mental health, health and senior services and elementary and secondary education, as applicable, regarding the projected budget of the entire MO HealthNet program including projected MO HealthNet enrollment growth, categorized by population and geographic area. The committee shall consist of ten members:

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

(2) The chair and the ranking minority member of the senate committee on appropriations **[**committee**]**;

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

(4) The chair and the ranking minority member of the standing senate committee **[**on health and mental health**]** assigned to consider MO HealthNet legislation and matters;

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

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

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

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

3. The committee shall meet **[**as necessary**]** at least twice a year. In the event of three consecutive absences on the part of any member, such member may be removed from the committee.

4. **[**Nothing in this section shall be construed as authorizing the committee to hire employees or enter into any employment contracts**]** The committee is authorized to hire an employee or enter into employment contracts, including an executive director to assist the committee with its duties. The compensation of such personnel and the expenses of the committee shall be paid from the joint contingent fund or jointly from the senate and house contingent funds until an appropriation is made therefor.

5. **[**The committee shall receive and study the five-year rolling MO HealthNet budget

forecast issued annually by the legislative budget office.

6.**]** The committee shall annually conduct a rolling five-year MO HealthNet forecast and make recommendations in a report to the general assembly by January first each year, beginning in **[**2008**]** 2015, on anticipated growth in the MO HealthNet program, needed improvements, anticipated needed appropriations, and suggested strategies on ways to structure the state budget in order to satisfy the future needs of the program. The departments of social services, health and senior services, and mental health shall provide information to the committee and its executive director as necessary to complete the forecast and report.

208.960. Health care professionals licensed under chapter 331 shall be reimbursed under the MO HealthNet program for providing services currently covered under section 208.152 and within the scope of practice under section 331.010.

208.975. 1. There is hereby created in the state treasury the "Health Care Technology Fund" which shall consist of all gifts, donations, transfers, and moneys appropriated by the general assembly, and bequests to the fund. The state treasurer shall be custodian of the fund and may approve disbursements from the fund in accordance with sections 30.170 and 30.180. The fund shall be administered by the department of social services **[**in accordance with the recommendations of the MO HealthNet oversight committee**]** unless otherwise specified by the general assembly. Moneys in the fund shall be distributed in accordance with specific appropriation by the general assembly. The director of the department of social services shall submit his or her recommendations for the disbursement of the funds to the governor and the general assembly.

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

(1) Electronic medical records;

(2) Community health records;

(3) Personal health records;

(4) E-prescribing;

(5) Telemedicine;

(6) Telemonitoring; and

(7) Electronic access for participants and providers to obtain MO HealthNet service authorizations.

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

4. For purposes of this section, "elected public official or any state employee" means a

person who holds an elected public office in a municipality, a county government, a state government, or the federal government, or any state employee, and the spouse of either such person, and any relative within one degree of consanguinity or affinity of either such person.

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

6. Any business or corporation which receives moneys expended from the health care technology fund in excess of five hundred thousand dollars in exchange for products or services and, during a period of two years following receipt of such funds, employs or contracts with any current or former elected public official or any state employee who had any direct decision-making or administrative authority over the awarding of health care technology fund contracts or the disbursement of moneys from the fund shall be subject to the provisions contained within subsection 5 of this section. Employment of or contracts with any current or former elected public official or any state employee which commenced prior to May 1, 2007, shall be exempt from these provisions.

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

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

9. The MO HealthNet division shall promulgate rules setting forth the procedures and methods implementing the provisions of this section and establish criteria for the disbursement of funds under this section to include but not be limited to grants to community health networks that provide the majority of care provided to MO HealthNet and low-income uninsured individuals in the community, and preference for health care entities where the majority of the patients and clients served are either participants of MO HealthNet or are from the medically underserved population. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

208.985. 1. Pursuant to section 33.803, by January 1, 2008, and each January first thereafter, the legislative budget office shall annually conduct a rolling five-year MO HealthNet forecast. The forecast shall be issued to the general assembly, the governor**[**,**]** and the joint committee on MO HealthNet**[**, and the oversight committee established in section 208.955**]**. The forecast shall include, but not be limited to, the following, with additional items as determined by the legislative budget office:

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

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

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

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

(5) Projected financial need going forward.

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

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

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

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

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

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

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

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

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

5. Notwithstanding any other provisions of law to the contrary, to be eligible for MO HealthNet coverage under section 208.991, individuals shall meet the eligibility requirements set forth in subsection 1 of this section and all other eligibility criteria set forth in 42 CFR 435 and 457, including, but not limited to, the requirements that:

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

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

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

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

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

6. The MO HealthNet program shall not provide MO HealthNet coverage under subsection 4 of section 208.991 to a parent or other caretaker relative living with a dependent child unless the child is receiving benefits under the MO HealthNet program, the Children's Health Insurance Program (CHIP) under 42 CFR Chapter IV, Subchapter D, or otherwise is enrolled in minimum essential coverage as defined in 42 CFR 435.4.

7. (1) The provisions of subsection 7 of section 208.151, subsection 2 of section 208.659, subsection 6 of section 208.990, subdivisions (1) and (7) of subsection 1 of section 208.991, subsections 4 to 12 and 16 of section 208.991, and sections 208.997, 208.998, and 208.999 shall be null and void unless and until:

(a) The federal Department of Health and Human Services grants the required waivers, state plan amendments, and enhanced federal funding rate for persons newly eligible under subsection 4 of section 208.991 whereby the federal government agrees to pay the percentages specified in Section 2001 of PL 111-148, as that section existed on March 23, 2010;

(b) The federal Department of Health and Human Services grants the enhanced federal funding rate for the department to provide coverage for persons under subsection 9 of section 208.991;

(2) If the federal funds at the disposal of the state shall at any time become less than ninety percent of the funds necessary to cover the cost of benefits provided to MO HealthNet participants eligible for coverage under subsection 4 of section 208.991 or are not appropriated to pay the percentages specified in Section 2001 of Public Law 111-148, as that section existed on March 23, 2010, the provisions listed in subdivision (1) of this subsection shall be null and void. Participants will be notified upon enrollment, and as soon as practicable if the director of the department is notified that federal funding will fall below ninety percent of the funds necessary to cover the cost of benefits provided to MO HealthNet participants eligible for coverage under subsection 4 of section 208.991, that the benefits they receive under subsection 4 of section 208.991 will terminate on the date that federal funding falls below ninety percent.

208.991. 1. For purposes of **[**this section and section 208.990**]** sections 208.990 to 208.998, the following terms mean:

(1) "Caretaker relative", a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, which may, but is

not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes, and who is one of the following:

(a) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece; or

(b) The spouse of such parent or relative, even after the marriage is terminated by death or divorce;

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

[(2)**]** (3) "CHIP-eligible children", children who meet the eligibility standards for Missouri's children's health insurance program as provided in sections 208.631 to 208.658, including paying the premiums required under sections 208.631 to 208.658;

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

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

(a) Any foreign earned income or housing costs;

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

(c) Tax-exempt Social Security income;

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

(7) "Medically frail", individuals:

(a) Described in 42 CFR 438.50(d)(3);

(b) Who are children with serious emotional disturbances;

(c) With disabling mental disorders;

(d) With chronic substance use disorders;

(e) With serious and complex medical conditions;

(f) With a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or

(g) With a disability determination based on Social Security criteria, including a current determination by the division that he or she is permanently and totally disabled.

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

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

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

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

(d) Pregnant women as provided in subdivisions (10), (11), and (12) of subsection 1 of section 208.151;

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

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

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

(h) CHIP-eligible children**[**; and

(i) Uninsured women as provided in section 208.659**]**.

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

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

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

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

(d) For individuals listed in **[**paragraphs (d),**]** paragraph (e)**[**, and (i)**]** of subdivision (1) of this subsection, the department shall apply one hundred eighty-five percent of the federal poverty level converted to the MAGI equivalent net income standard;

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

3. No later than January 1, 2015, the department shall implement an automated process to ensure applicants applying for benefit programs are eligible for such programs. The automated process shall be designed to periodically review current beneficiaries to ensure that they remain eligible for benefits they are receiving. The system shall check applicant and recipient information against multiple sources of information through an automated process. This requirement shall only become effective if the necessary funding is appropriated to implement the system.

4. (1) Effective January 1, 2015, and subject to the receipt of appropriate waivers and approval of state plan amendments, individuals who meet the following qualifications shall be eligible for alternative benefit plans as set forth in section 208.998, subject to the other requirements of this section:

(a) Are nineteen years of age or older and under sixty-five years of age;

(b) Are not pregnant;

(c) Are not entitled to or enrolled for Medicare benefits under Part A or B of Title XVIII of the Social Security Act;

(d) Are not otherwise eligible for and enrolled in mandatory coverage under the MO HealthNet program in accordance with 42 CFR 435, Subpart B; and

(e) Have household income that is at or below one hundred thirty-three percent of the federal poverty level for the applicable family size for the applicable year as converted to the MAGI

equivalent net income standard except the household income may be reduced by a dollar amount equivalent to five percent of the federal poverty level for the applicable family size as required under 42 U.S.C. Section 1396a(e)(14)(I)(i).

(2) The department shall immediately seek any necessary waivers from the federal Department of Health and Human Services to implement the provisions of this subsection. The waivers shall:

(a) Promote healthy behavior and reasonable requirements that patients take ownership of their health care by seeking early preventive care in appropriate settings, including no co-payments for preventive care services;

(b) Require personal responsibility in the payment of health care by establishing appropriate co-payments based on family income that shall discourage the use of emergency department visits for non-emergent health situations and promote responsible use of other health care services;

(c) Promote the adoption of healthier personal habits including limiting tobacco use or behaviors that lead to obesity;

(d) Allow recipients to receive an annual incentive to promote responsible behavior and encourage efficient use of health care services. Incentives shall have some health or child development-related functions, and may include clothing, utilities, child care, public transportation, food, books, safety devices, over-the-counter drugs available without prescription except pseudoephedrine, diapers or other infant care items, telecommunications subscriptions to publications that include health-related subjects, and memberships in clubs advocating educational advancement and healthy lifestyles. Incentives shall not include the provision of gambling, alcohol, tobacco, or drugs, except over-the-counter drugs, and the department shall notify participants that the incentive may not be used for such purposes;

(e) Allow managed care organizations and other health plans to offer a health savings account option; and

(f) Include a request for an enhanced federal funding rate consistent with subsection 14 of this section for newly eligible participants.

(3) If such waivers and enhanced federal funding rate are not granted by the federal government, the provisions of this subsection shall be null and void.

5. Except for those individuals who meet the definition of medically frail, individuals eligible for MO HealthNet benefits under subsection 4 of this section shall receive only an alternative benefit plan. The MO HealthNet division of the department of social services shall promulgate regulations to be effective January 1, 2015, that provide an alternative benefit plan that complies with the requirements of federal law and is subject to limitations as established in regulations of the MO HealthNet division.

6. The department shall require cost sharing to the maximum extent allowed by law for participants eligible under subsection 4 of this section with incomes between and inclusive of fifty and one hundred percent of the federal poverty level for the applicable family size, for the applicable year, including but not limited to a premium of no less than one percent of the participant's income as converted to the MAGI equivalent net income standard. In order to collect the required cost sharing under this subsection, the department may recover from the participant's Missouri income tax refund

pursuant to sections 143.782 to 143.788.

7. The department shall apply for a Section 1115 waiver to encourage workforce participation of individuals eligible for MO HealthNet benefits under subsection 4 of this section such that eligible individuals over the age of eighteen who are not elderly, disabled, pregnant, or medically frail. Participants who provide proof of workforce participation shall be eligible to receive a reduction in the cost sharing amount owed under subsections 6 and 9 of this section. Participants who do not provide proof of workforce participation as required under this subsection shall be referred to the family support division or the department of economic development for job-finding assistance.

8. The department shall provide premium subsidy and other cost supports for individuals eligible for MO HealthNet under subsections 2 and 4 of this section to enroll in employer-provided health plans or other private health plans based on cost-effective principles determined by the department.

9. Effective January 1, 2015, the department shall provide health care coverage for persons who have an income between one hundred percent and one hundred thirty-three percent of the federal poverty level for the applicable family size, for the applicable year as converted to the MAGI equivalent net income standard, who meet all other requirements of subsection 4 of this section and have not been determined to be medically frail by the department, through a health care exchange operating in this state, whether federally facilitated, state based, or operated on a partnership basis, or an employer. The department shall ensure the participants receive the minimum services required to ensure federal reimbursement at the percentages specified in Section 2001 of Public Law 111-148. The department of insurance, financial institutions and professional registration is authorized to provide health plan management support as necessary to facilitate the purchase of health benefit services by the MO HealthNet Division through an exchange under this subsection. The department of social services shall require cost sharing to the maximum extent allowed by law.

10. Effective January 1, 2015, all persons eligible for MO HealthNet benefits under subsection 4 of this section who are determined to be medically frail shall receive all benefits they otherwise qualify for that are available to an aged, blind, or disabled adult.

11. The department shall establish a screening process in conjunction with the department of mental health and the department of health and senior services for determining whether an individual is medically frail and shall enroll all eligible individuals who are determined to be medically frail and whose care management would benefit from being assigned a health home in the health home program or other care coordination as established by the department. Any eligible individual may opt out of the health home program.

12. For individuals who meet the definition of medically frail, the department shall develop an incentive program to promote the adoption of healthier personal habits, including limiting tobacco use or behaviors that lead to obesity, and for those individuals who utilize the health home program in subsection 11 of this section.

13. All participants eligible for MO HealthNet benefits under subsection 4 of this section shall annually sign and comply with a membership agreement mandating completion of required preventive care services and wellness activities as specified by rule of the department.

(1) Participants who complete all required preventive care services and wellness activities during their initial year of eligibility shall be eligible to receive benefit payments for dental services during the subsequent year of eligibility and each year thereafter until such time as the participant fails to complete required preventive care services and wellness activities specified during the prior annual eligibility period.

(2) Participants who do not complete all required preventive care services and wellness activities during their initial year of eligibility shall not be eligible to receive benefit payments for dental services during the subsequent year of eligibility, but shall be eligible to receive benefit payments for dental services in any year immediately following a year in which the participant does complete all required preventive care services and wellness activities specified during the prior annual eligibility period.

(3) A participant's annual eligibility period under this subsection shall reset if the participant is not eligible for MO HealthNet benefits for one hundred eighty consecutive days.

(4) Participants who do not sign a membership agreement under this subsection shall not be eligible to receive the dental service incentive available to participants under this subsection, but in no way shall failure to sign a membership agreement impact eligibility or benefits under any other provision of law.

(5) This subsection shall be null and void unless and until state plan amendments and waivers necessary to implement this subsection have been approved by the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

14. The department or appropriate divisions of the department shall promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as the term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2013, shall be invalid and void.

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

16. If at any time the director receives notice that the federal funds at the disposal of the state for payments of money benefits to or on behalf of any persons under subsection 4 of this section shall at any time become less than ninety percent of the funds necessary to cover the cost of benefits provided to MO HealthNet participants eligible for coverage under subsections 4, 5, 8, 9, 10, 12, and 13 of this section or are not appropriated to pay the percentages specified in Section 2001 of Public Law 111-148, as that section existed on March 23, 2010, subsections 4 to 13 of this section shall no longer be effective for the individuals whose benefits are no longer matchable at the specified percentages. The date benefits cease shall be stated in a notice sent to the affected individuals.

17. Participants enrolling in coverage under subsection 4 of this section shall be notified upon enrollment that coverage under subsection 4 to 13 of this section is a demonstration initiative

and shall end on January 1, 2020, unless reauthorized by the general assembly, and that coverage under subsection 4 through 13 of this section may end upon a reduction in federal funding pursuant to subsection 16 of this section.

18. The provisions of subsections 4 to 13 of this section shall sunset on January 1, 2020, unless reauthorized by an act of the general assembly.

208.997. 1. The MO HealthNet division shall develop and implement the "Health Care Homes Program" as a provider-directed care coordination program for MO HealthNet recipients who are not enrolled in a prepaid MO HealthNet benefits option and who are receiving services on a fee-for-service basis or are otherwise identified by the department. The health care homes program shall provide payment to primary care clinics, community mental health centers, and other appropriate providers for care coordination for individuals who are determined to be medically frail. Clinics shall meet certain criteria, including but not limited to the following:

(1) The capacity to develop care plans;

(2) A dedicated care coordinator;

(3) An adequate number of clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement; and

(4) The capability to maintain and use a disease registry.

2. For purposes of this section, "primary care clinic" means a medical clinic designated as the patient's first point of contact for medical care, available twenty-four hours a day, seven days a week, that provides or arranges the patient's comprehensive health care needs and provides overall integration, coordination, and continuity over time and referrals for specialty care.

3. The department may designate that the health care homes program be administered through an organization with a statewide primary care presence, experience with MO HealthNet population health management, and an established health care homes outcomes monitoring and improvement system.

4. This section shall be implemented in such a way that it does not conflict with federal requirements for health care home participation by MO HealthNet participants.

5. The department or appropriate divisions of the department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly under chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

6. Nothing in this section shall be construed to limit the department's ability to create health care homes for participants in a managed care plan.

208.998. 1. The department of social services shall seek a state plan amendment to extend the current MO HealthNet managed care program statewide no earlier than January 1, 2015, and no later than July 1, 2015, for all eligibility groups currently enrolled in a managed care plan as of January 1, 2014.

2. Except for individuals who meet the definition of medically frail, individuals who qualify for coverage under subsections 2 and 4 of section 208.991 and are not receiving benefits or services under subsections 8 or 9 of section 208.991 shall receive covered services through health plans offered by managed care entities under subsection 1 of this section which are authorized by the department.

3. The department may designate that certain health care services be excluded from such health plans if it is determined cost effective by the department.

4. (1) The department shall review and may accept regional proposals as an additional option for beneficiaries. Such regional proposals shall include, but not be limited to, provider sponsored care management initiatives designed to improve health outcomes and reduce spending.

(2) The department may advance the development of systems of care for medically complex children who are recipients of MO HealthNet benefits by accepting cost-effective regional proposals from and contracting with appropriate pediatric care networks, pediatric centers for excellence, and medical homes for children to provide MO HealthNet benefits when the department determines it is cost effective to do so.

(3) The provisions of subsection 1 of this section shall not apply to this subdivision.

5. The department shall establish, in collaboration with plans and providers, uniform utilization review protocols to be used by all authorized health plans.

6. This section shall not be construed to require the department to terminate any existing managed care contract or to extend any managed care contract.

7. All MO HealthNet plans under this section shall provide coverage for the following services unless they are specifically excluded under subsection 3 of this section and instead are provided by an administrative services organization:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance abuse treatment, including behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness care, and chronic disease management;

(10) Any other services required by federal law.

8. Managed care organizations shall implement incentive based initiatives with primary care providers to coordinate care and achieve improvements in service delivery.

9. No MO HealthNet plan or program shall provide coverage for an abortion unless a physician certifies in writing to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term.

10. The department shall seek all necessary waivers and state plan amendments from the federal Department of Health and Human Services necessary to implement the provisions of this section. The provisions of this section shall not be implemented unless such waivers and state plan

amendments are approved. If this section is approved in part by the federal government, the department is authorized to proceed on those sections for which approval has been granted; except that, any increase in eligibility shall be contingent upon the receipt of all necessary waivers and state plan amendments. The provisions of this section shall not be implemented until the provisions of subsection 4 of section 208.991 have been approved by the federal Department of Health and Human Services and have been implemented by the department. However, nothing shall prevent the department from expanding managed care for populations under other granted authority.

11. The MO HealthNet division shall develop transitional spending plans prior to January 1, 2015, if necessary, for the purpose of continuing and preserving payments consistent with current MO HealthNet levels for community mental health centers (CMHCs), which act as administrative entities of the department of mental health and serve as safety net providers. The MO HealthNet division shall create an implementation workgroup consisting of the MO HealthNet division, the department of mental health, CMHCs, and managed care organizations in the MO HealthNet program.

12. The department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as the term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly under chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

13. (1) No MO HealthNet managed care organization shall refuse to contract with any licensed Missouri medical doctor, doctor of osteopathy, psychiatrist or psychologist who is located within the geographic coverage area of a MO HealthNet managed care program and meets the credentialing criteria established by the National Committee for Quality Assurance, and is willing, as a term of contract, to be paid at rates equal to one hundred percent of the MO HealthNet Medicaid fee schedule.

(2) In the MO HealthNet managed care program under this subdivision, all provisional licensed clinical social workers, licensed clinical social workers, provisional licensed professional counselors and licensed professional counselors may provide behavioral health services to all participants in any setting. No MO HealthNet managed care organization shall refuse to contract with any provider under this subdivision so long as the provider is located within the geographic coverage area of a MO HealthNet managed care program, meets the credentialing criteria established by the National Committee for Quality Assurance, and is willing, as a term of contract, to be paid at rates equal to one hundred percent of the MO HealthNet Medicaid fee schedule.

(3) Nothing in this subsection shall require a MO HealthNet managed care organization to contract with a willing provider if the managed care organization is prohibited by law from doing so.

208.999. 1. Managed care organizations shall be required to provide to the department of social services, on at least a yearly basis, and the department of social services shall publicly report within thirty days of receipt, including posting on the department's website, at least the following

information:

(1) Medical loss ratios for each managed care organization compared with the eighty-five percent medical loss ratio for large group commercial plans under Public Law 111-148 and, where applicable, with the state's administrative costs in its fee-for-service MO HealthNet program;

(2) Total payments to the managed care organization in any form, including but not limited to tax incentives and capitated payments to participate in MO HealthNet, and total projected state payments for health care for the same population without the managed care organization.

2. Managed care organizations shall be required to post all of their provider networks online and shall regularly update their postings of these networks on a timely basis regarding all changes to provider networks. A provider how is seeing only existing patients under a given managed care plan shall not be so listed.

3. The department of social services shall be required to contract with an independent organization that does not contract or consult with managed care plans or insurers to conduct secret shopper surveys of MO HealthNet managed care plans for compliance with provider network adequacy standards on a regular basis, to be funded by the managed care organizations out of their administrative budgets, not to exceed ten-thousand dollars annually. Secret shopper surveys are a quality assurance mechanism under which individuals posing as managed care enrollees will test the availability of timely appointments with providers listed as participating in the network of a given plan for new patients. The testing shall be conducted with various categories of providers, with the specific categories rotated for each survey and with no advance notice provided to the managed health plan. If an attempt to obtain a timely appointment is unsuccessful, the survey records the particular reason for the failure, such as the provider not participating in MO HealthNet at all, not participating in MO HealthNet under the plan which listed them and was being tested, or participating under that plan but only for existing patients.

4. Inadequacy of provider networks, as determined from the secret shopper surveys or the publication of false or misleading information about the composition of health plan provider networks, may be the basis requiring the plan to take prompt and effective corrective action, and for the imposition of sanctions against the offending managed care organization as determined by the department.

5. The provider compensation rates for each category of provider shall also be reported by the managed care organizations to help ascertain whether they are paying enough to engage providers comparable to the number of providers available to commercially insured individuals, as required by federal law, and compared, where applicable, to the state's own provider rates for the same categories of providers.

6. Managed care organizations shall be required to provide, on a quarterly basis and for prompt publication, at least the following information related to service utilization, approval, and denial:

(1) Service utilization data, including how many of each type of service was requested and delivered, subtotaled by age, race, gender, geographic location, and type of service;

(2) Data regarding denials and partial denials by managed care organizations or their subcontractors each month for each category of services provided to MO HealthNet enrollees.

Denials include partial denials whereby a requested service is approved but in a different amount, duration, scope, frequency, or intensity than requested; and

(3) Data regarding complaints, grievances, and appeals, including numbers of complaints, grievances, and appeals filed, subtotaled by race, age, gender, geographic location, and type of service, including the timeframe data for hearings and decisions made and the dispositions and resolutions of complaints, grievances, or appeals.

7. Managed care organizations shall be required to disclose the following information:

(1) Quality measurement data including, at minimum, all health plan employer data and information set (HEDIS) measures, early periodic screening, diagnosis, and treatment (EPSDT) screening data, and other appropriate utilization measures;

(2) Consumer satisfaction survey data;

(3) Enrollee telephone access reports including, average wait time before managed care organization or subcontractor response, busy signal rate, and enrollee telephone call abandonment rate;

(4) Data regarding the average cost of care of individuals whose care is reported as having been actively managed by the managed care organization versus the average cost of care of the managed care organization's population generally. For purposes of this section, the phrase "actively managed by the managed care organization" means the managed care organization has actually developed a care plan for the particular individual and is implementing it as opposed to reacting to prior authorization requests as they come in, reviewing usage data, or monitoring doctors with high utilization;

(5) Data regarding the number of enrollees whose care is being actively managed by the managed care organization, broken down by whether the individuals are hospitalized, have been hospitalized in the last thirty days, or have not recently been hospitalized;

(6) Results of network adequacy reviews including geo-mapping, stratified by factors including provider type, geographic location, urban or rural area, any findings of adequacy or inadequacy, and any remedial actions taken. This information shall also include any findings with respect to the accuracy of networks as published by managed care organizations, including providers found to be not participating and not accepting new patients;

(7) Any data related to preventable hospitalizations, hospital-acquired infections, preventable adverse events, and emergency department admissions; and

(8) Any additional reported data obtained from the managed care plans which relates to the performance of the plans in terms of cost, quality, access to providers or services, or other measures."; and

Further amend said bill, Page 6, Section 376.2004, Line 49, by inserting after all of said section and line the following:

"660.013. 1. There is hereby created in the state treasury the "Medicaid Savings Budget and Taxpayer Protection Fund" which shall consist of money collected under subsection 2 to 4 of this section. The state treasurer shall be custodian of the fund and may approve disbursements in

accordance with sections 30.170 and 30.180. The fund shall be a dedicated fund and, upon appropriation, money in the fund shall be used solely for the purposes of subsection 7 of this section. Notwithstanding the provisions of 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund. The state treasurer shall invest moneys in the fund in the same manner as other funds invested. Any interest and moneys earned on such investments shall be credited to the fund.

2. The office of administration in conjunction with the departments of social services and mental health shall track the general revenue savings achieved due to:

(1) The reduction in the number of participants determined eligible under the provisions of sections 208.145, 208.146, 208.151, 208.631 to 208.659, and subsection 2 of section 208.991, as a result of expansion of Medicaid eligibility to one hundred-thirty three percent of the federal poverty level and as a result of federal subsidies available under the federal health care exchange, whether federally facilitated, state based, or operated on a partnership basis; and

(2) The reduction in the number of participants in state programs paid for with state-only funds as a result of expansion of Medicaid eligibility to one hundred thirty-three percent of the federal poverty level and as a result of federal subsidies available under the federal health care exchange, whether federally facilitated, state based, or operated on a partnership basis.

3. The department of social services shall determine the additional pharmacy provider assessment revenue generated as a result of expansion of Medicaid eligibility to one hundred thirty-three percent of the federal poverty level. The department of social services shall determine the amount of that additional pharmacy provider assessment that is needed to make payments to pharmacies for services for those eligible under subsection 4 of section 208.991. Any amount generated that is not needed for such payments shall be reported as excess and may be transferred pursuant to subsection 6 of this section.

4. The department of social services shall determine the additional hospital provider assessment revenue generated as a result of expansion of Medicaid eligibility to one hundred thirty-three percent of the federal poverty level. The department of social services shall determine the amount of that additional hospital provider assessment that is needed to make payments to hospitals for services for those eligible under subsection 4 of section 208.991. Any amount generated that is not needed for such payment shall be reported as excess and may be transferred pursuant to subsection 6 of this section and solely be used to make payments to hospitals for individuals eligible for Medicaid services as a result of expansion of eligibility to one hundred and thirty three percent of the federal poverty level pursuant to subsection 4 of section 208.991.

5. By October first of each year, the office of administration shall report the amounts pursuant to subsections 2, 3, and 4 of this section for the prior fiscal year to the governor, the chair of the house of representatives budget committee, and the chair of the senate appropriations committee.

6. The office of administration shall, subject to appropriation, transfer the amounts reported pursuant to subsection 5 of this section to the Medicaid savings state budget and taxpayer protection fund. The transfers shall be made in three installments of relatively equal size no later than November, February, and May of each fiscal year.

7. Subject to appropriation, moneys in the Medicaid savings state budget and taxpayer

protection fund shall be used solely to pay the general revenue share of costs for individuals eligible for Medicaid services as a result of expansion of eligibility to one hundred thirty-three percent of the federal poverty level pursuant to subsection 4 of section 208.991.

8. If revenue in the Medicaid savings state budget and taxpayer protection fund is not sufficient to cover the general revenue share of the costs outlined in subsection 7 of this section, rates paid to providers for those services shall be reduced accordingly. Provider rates that shall be subject to reduction under this subsection shall include rates paid to hospitals, federally qualified health centers, rural health clinics, community mental health centers, pharmacies, physicians, chiropractors, and Medicaid managed care plans.

9. The department of social services shall seek any waivers or state plan amendments that are necessary to implement the provisions of this section.

10. If, due to federal requirements, rates to one or more of the provider types listed in subsection 8 of this section cannot be reduced sufficiently to cover the costs outlined in subsection 7 of this section, rates to the remaining providers listed in subsection 8 shall be reduced by no more than an additional five percent.

11. If the United States Congress passes legislation to convert the Medicaid program into a block grant program, the department of social services shall seek the necessary approval to operate Missouri's Medicaid program under a block grant program within six months of federal implementation of such program.

[208.955. 1. There is hereby established in the department of social services the "MO HealthNet Oversight Committee", which shall be appointed by January 1, 2008, and shall consist of nineteen members as follows:

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

(2) Two members of the Senate, one from each party, appointed by the president pro tem of the senate and the minority floor leader of the senate;

(3) One consumer representative who has no financial interest in the health care industry and who has not been an employee of the state within the last five years;

(4) Two primary care physicians, licensed under chapter 334, who care for participants, not from the same geographic area, chosen in the same manner as described in section 334.120;

(5) Two physicians, licensed under chapter 334, who care for participants but who are not primary care physicians and are not from the same geographic area, chosen in the same manner as described in section 334.120;

(6) One representative of the state hospital association;

(7) Two nonphysician health care professionals, the first nonphysician health care professional licensed under chapter 335 and the second nonphysician health care professional licensed under chapter 337, who care for participants;

(8) One dentist, who cares for participants, chosen in the same manner as described in section 332.021;

(9) Two patient advocates who have no financial interest in the health care industry and who have not been employees of the state within the last five years;

(10) One public member who has no financial interest in the health care industry and who has not been an employee of the state within the last five years; and

(11) The directors of the department of social services, the department of mental health, the department of health and senior services, or the respective directors' designees, who shall serve as ex-officio members of the committee.

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

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

(2) Review the participant and provider satisfaction reports and the reports of health outcomes, social and behavioral outcomes, use of evidence-based medicine and best practices as required of the health improvement plans and the department of social services under section 208.950;

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

(4) Review the results of studies comparing health plans conducted under section 208.950;

(5) Review the data from health risk assessments collected and reported under section 208.950;

(6) Review the results of the public process input collected under section 208.950;

(7) Advise and approve proposed design and implementation proposals for new health improvement plans submitted by the department, as well as make recommendations and suggest modifications when necessary;

(8) Determine how best to analyze and present the data reviewed under section 208.950 so that the health outcomes, participant and provider satisfaction,

results from other states, health plan comparisons, financial impact of the various health improvement plans and models of care, study of provider access, and results of public input can be used by consumers, health care providers, and public officials;

(9) Present significant findings of the analysis required in subdivision (8) of this subsection in a report to the general assembly and governor, at least annually, beginning January 1, 2009;

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

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

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

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

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

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

3. By July 1, 2011, the oversight committee shall issue findings to the general assembly on the success and failure of health improvement plans and shall recommend whether or not any health improvement plans should be discontinued.

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

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

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

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

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

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

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

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

5. The subcommittee shall include the following members:

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

(2) One member from a Missouri area agency on aging, designated by the governor;

(3) One member representing the in-home care profession, designated by the governor;

(4) One member representing residential care facilities, predominantly serving MO HealthNet participants, designated by the governor;

(5) One member representing assisted living facilities or continuing care retirement communities, predominantly serving MO HealthNet participants, designated by the governor;

(6) One member representing skilled nursing facilities, predominantly serving MO HealthNet participants, designated by the governor;

(7) One member from the office of the state ombudsman for long-term care facility residents, designated by the governor;

(8) One member representing Missouri centers for independent living, designated by the governor;

(9) One consumer representative with expertise in services for seniors or persons with a disability, designated by the governor;

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

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

(12) One member representing the hospice care profession, designated by the governor;

(13) One member representing the home health care profession, designated by the governor;

(14) One member representing the adult day care profession, designated by the governor;

(15) One member gerontologist, designated by the governor;

(16) Two members representing the aged, blind, and disabled population, not of the same geographic area or demographic group designated by the governor;

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

(18) One member of the house of representatives and one member of the senate serving on the oversight committee, designated by the oversight committee chair.

Members shall serve on the subcommittee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of health and senior services for that purpose. The department of health and senior services shall provide technical and administrative support services as required by the committee.

6. By October 1, 2008, the comprehensive entry point system subcommittee shall submit its report to the governor and general assembly containing recommendations for the implementation of the comprehensive entry point system, offering suggested legislative or administrative proposals deemed necessary by the subcommittee to minimize conflict of interests for successful implementation of the system. Such report shall contain, but not be limited to, recommendations for implementation of the following consistent with the provisions of section 208.950:

(1) A complete statewide universal information and assistance system 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 and is used to establish consumers' needs for services. Through the system, consumers shall be able to independently choose from a full range of home, community-based, and facility-based health and social services as well as access appropriate services to meet individual needs and preferences from the provider of the consumer's choice;

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

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

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

(5) 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 shall not apply to sections 208.950 to 208.955.**]**"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.