SECOND REGULAR SESSION

HOUSE BILL NO. 1213

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE GUERNSEY.

4846H.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 208.010, 208.022, 208.027, 208.042, 208.048, 208.152, and 208.182, RSMo, and to enact in lieu thereof eleven new sections relating to public assistance, with penalty provisions.

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

Section A. Sections 208.010, 208.022, 208.027, 208.042, 208.048, 208.152, and 208.182, RSMo, are repealed and eleven new sections enacted in lieu thereof, to be known as sections 208.010, 208.022, 208.027, 208.031, 208.042, 208.048, 208.152, 208.182, 208.249, 1, and 2, to read as follows:

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

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

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 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 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**]** **all relatives, members of the household, and any other individuals who are twenty-one years of age or**

older and 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.

208.022. All electronic benefits cards distributed to recipients of temporary assistance for needy families benefits 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. **Retail establishments shall be required to verify that the photograph on the card matches the identity of the person presenting the card.** 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.

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 administrative hearing decision 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 administrative hearing decision. 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. 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. 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. 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, shall be invalid and void.

5. Notwithstanding the department's screening program developed under subsection 1 of this section, case workers shall be given the ultimate discretion to determine whether there is reasonable cause to believe an applicant or recipient engages in the illegal use of controlled substances. The department is prohibited from promulgating any rule or policy that would prohibit a case worker of applicants or recipients from requiring a test for any applicant or recipient the case worker has reasonable cause to believe engages in the illegal use of controlled substances.

6. Any department employee who prohibits the drug testing of an applicant or recipient when the case worker has reasonable cause to believe the applicant or recipient engages in the illegal use of controlled substances shall be subject to immediate termination of employment.

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, 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 administrative hearing decision. 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.

208.042. 1. In households containing recipients of **[**aid to families with dependent children**]** **temporary assistance for needy families** benefits, each **[**appropriate child, relative or other eligible individual**]** **recipient** sixteen years of age or over**, with the exception of recipients under the age of nineteen who are enrolled full-time in high school,** shall **[**be referred by the division of family services to the United States Secretary of Labor or his representative for participation in employment, training, work incentive or special work projects when established and operated by the secretary,**]** **participate in work activities in accordance with federal regulations** to afford such individuals opportunities to work in the regular economy and to attain independence through gainful employment.

2. The **[**division of family services**]** **department of social services**, pursuant to applicable federal law and regulations, shall determine the standards and procedures for the referral of individuals for **[**employment, training, work incentive and special work projects,**]** **work activities,** which shall not be refused by such individuals without good cause; but no recipient **[**or other eligible individual in the household**]** shall be required to participate in such work **[**programs**]** **activities** if the person is

(1) Ill, incapacitated, or of advanced age;

(2) So remote from the location of any work **[**or training project or program**]** **activity** that he cannot effectively participate;

(3) A child attending school full time;

(4) A person whose presence in the household on a substantially continuous basis is required because of illness or incapacity of another member of the household.

3. [The division of family services shall pay to the United States Secretary of Labor or his representative up to twenty percent of the total cost, in cash or in kind, of the work incentive programs operated for the benefit of the eligible persons referred by the division of family services; and the division of family services shall pay an amount to the secretary for eligible persons referred to and participating in special work projects not to exceed the maximum monthly payments authorized under sections 208.041 and 208.150 for recipients of public assistance benefits. An allowance in addition to the maximum fixed by section 208.150 may also be made by the division of family services for the reasonable expenses of any needy child or needy eligible relative which are attributable to his participating in a work training or work incentive program.

4.] If [an eligible child or relative] **a recipient** refuses without good cause to participate in any work [training or work incentive program to which he has been referred, payment to or on behalf of the child or relative] **activity, his or her benefits** may be continued for not more than sixty days thereafter, but in such cases payments shall be made pursuant to subsection 2 of section 208.180. If a [relative] **recipient** has refused to so participate, payments on behalf of the eligible children cared for by the [relative] **recipient** shall be made pursuant to subsection 2 of section 208.180.

[5.] **4.** The [division of family services] **department of social services** is authorized to expend funds to provide child day care services, when appropriate, for the care of children required by the absence of adult persons from the household due to [referral and participation in employment, training, work incentive programs or special work projects] **work activities**.

5. The provisions of this section shall be subject to compliance by the department with all applicable federal laws and rules regarding temporary assistance for needy families.

208.048. 1. A dependent child eighteen years of age shall, in order to retain eligibility for aid to families with dependent children, be enrolled as a full-time student in a public or private secondary school, or an equivalent level of vocational or technical school in lieu of secondary school, and reasonably expected to complete the program of the secondary school, or equivalent vocational or technical training.

2. All recipients of temporary assistance benefits shall be required to provide proof that all dependent children who are eligible for enrollment in a public school are enrolled and attending school, whether public, private, or home school, regularly.

[2.**]** **3.** The department of social services shall promulgate rules and regulations to carry out the provisions of this section pursuant to section 660.017 and chapter 536.

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as defined in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

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

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

(3) Laboratory and X-ray services;

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

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

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

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

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

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

(10) Home health care services;

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

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

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

(14) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if her or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

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

and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

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

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

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

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

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

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

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

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

(1) Dental services;

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

(3) Optometric services as defined in section 336.010;

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

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

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (14) and (15) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder.

When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the **[**Missouri**]** MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

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

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

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

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

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

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

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

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

12. The MO HealthNet division shall screen all recipients of MO HealthNet benefits to determine if such recipients are eligible to participate in the health insurance premium payment (HIPP) program. All eligible recipients shall participate in the HIPP program if it is determined to be cost effective for the division.

208.182. 1. **[**The division of family services shall establish pilot projects in St. Louis City and in any county with a population of six hundred thousand or more, which shall provide for a system of electronic transfer of benefits to public assistance recipients. Such system shall allow recipients to obtain cash from automated teller machines or point of sale terminals. If less than the total amount of benefits is withdrawn, the recipient shall be given a receipt showing the current status of his account.**] All electronic benefit cards distributed to food stamp recipients shall have imprinted on the card a photograph of the recipient and shall expire and be subject to renewal after a period of three years. Retail establishments shall be required to verify that the photograph on the card matches the identity of the person presenting the card. 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. The disclosure of any information provided to a financial institution, business or vendor by the **[**division of family services**] department** pursuant to this section is prohibited.

Such financial institution, business or vendor may not use or sell such information and may not divulge the information without a court order. Violation of this subsection is a class A misdemeanor.

3. [Subject to appropriations and subject to receipt of waivers from the federal government to prevent the loss of any federal funds, the department of social services shall require the use of photographic identification on electronic benefit transfer cards issued to recipients in this system. Such photographic identification electronic benefit transfer card shall be in a form approved by the department of social services.

4.] The [division of family services] **department** shall promulgate rules and regulations necessary to implement the provisions of this section pursuant to section 660.017 and chapter 536. **The rules shall ensure compliance with federal law, taking into account individuals and households with special needs as well as ensuring that all appropriate household members or authorized representatives are able to access benefits as necessary.**

[5.] **4.** The delivery of electronic benefits and the electronic eligibility verification, including, but not limited to, [aid to families with dependent children (AFDC)] **temporary assistance for needy families (TANF)**, women, infants and children (WIC), early periodic screening diagnosis and treatment (EPSDT), food stamps, supplemental security income (SSI), including Medicaid, child support, and other programs, shall reside in one card that may be enabled by function from time to time in a convenient manner.

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. Any person who knowingly and intentionally commits fraud in obtaining or attempting to obtain public assistance benefits shall lose eligibility for public assistance benefits permanently.

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.

Section 1. Notwithstanding any provision of law to the contrary, the department shall establish and implement a welfare-to-work program that requires all recipients of temporary assistance for needy families benefits to make at least twenty job contacts per week. The department shall allow recipients to work as unpaid interns for a governmental entity and shall only require those working as interns to make at least ten job contacts per week. After the first month of making job contacts, any recipient of temporary assistance for needy families benefits that has not obtained employment that provides on average twenty hours per week of employment shall be required to work as an unpaid intern for a governmental entity and shall only be required to make at least ten job contacts per week. Any county, city or other political subdivision shall be allowed to submit to the department available intern positions in which temporary assistance recipients may be placed. The provisions of this section shall not apply to any recipient under the age of nineteen who is enrolled in high school full-time. The director of the department of social services shall apply for all waivers of requirements under federal law necessary to implement the provisions of this section with full federal participation. The provisions of this section shall be implemented, subject to appropriation, as waivers necessary to ensure continued federal participation are received.

Section 2. All recipients of temporary assistance for needy families, food stamps, child care assistance, supplemental nutrition assistance, or any other similar governmental assistance program who are eighteen years of age or older shall be required to possess a high school diploma or graduate equivalency degree. Any applicant for temporary assistance for needy families, food stamps, child care assistance, supplemental nutrition assistance, or any other similar governmental assistance program who, at the time of their application for assistance, does not possess a high school diploma or graduate equivalency

degree as required by these provisions shall have two years from the date of the application for assistance to obtain a high school diploma. If all other eligibility requirements are satisfied, the applicant shall receive assistance during such two-year period. The director of the department of social services shall apply for all waivers of requirements under federal law necessary to implement the provisions of this section with full federal participation. The provisions of this section shall be implemented, subject to appropriation, as waivers necessary to ensure continued federal participation are received.

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