

FIRST REGULAR SESSION

HOUSE BILL NO. 939

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES FITZPATRICK (Sponsor), HAAHR, ROWDEN,
ALLEN AND FLANIGAN (Co-sponsors).

1746H.021

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 208.010, 208.042, and 208.152, RSMo, and to enact in lieu thereof three new sections relating to public assistance.

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

Section A. Sections 208.010, 208.042, and 208.152, RSMo, are repealed and three new sections enacted in lieu thereof, to be known as sections 208.010, 208.042, and 208.152, to read as follows: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 division of family services 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 and 208.162 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 division of family services; 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

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.

16 income exceeds the amount necessary to meet the needs (as defined by rule or regulation of the
17 division) of such husband or wife living separately. In determining the need of a claimant in
18 federally aided programs there shall be disregarded such amounts per month of earned income
19 in making such determination as shall be required for federal participation by the provisions of
20 the federal Social Security Act (42 U.S.C.A. 301 et seq.), or any amendments thereto. When
21 federal law or regulations require the exemption of other income or resources, the division of
22 family services may provide by rule or regulation the amount of income or resources to be
23 disregarded.

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

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

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

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

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

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

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

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

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

64 (5) Prior to October 1, 1989, owns or possesses property of any kind or character,
65 excluding amounts placed in an irrevocable prearranged funeral or burial contract under chapter
66 436, or has an interest in property, of which he or she is the record or beneficial owner, the value
67 of such property, as determined by the division of family services, less encumbrances of record,
68 exceeds twenty-nine thousand dollars, or if married and actually living together with husband
69 or wife, if the value of his or her property, or the value of his or her interest in property, together
70 with that of such husband and wife, exceeds such amount;

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

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

85 3. In determining eligibility and the amount of benefits to be granted pursuant to
86 federally aided programs, the income and resources of [a relative or other person] **all relatives,**
87 **members of the household, and any other individuals who are twenty-one years of age or**

88 **older and** living in the home shall be taken into account to the extent the income, resources,
89 support and maintenance are allowed by federal law or regulation to be considered.

90 4. In determining eligibility and the amount of benefits to be granted pursuant to
91 federally aided programs, the value of burial lots or any amounts placed in an irrevocable
92 prearranged funeral or burial contract under chapter 436 shall not be taken into account or
93 considered an asset of the burial lot owner or the beneficiary of an irrevocable prearranged
94 funeral or funeral contract. For purposes of this section, "burial lots" means any burial space as
95 defined in section 214.270 and any memorial, monument, marker, tombstone or letter marking
96 a burial space. If the beneficiary, as defined in chapter 436, of an irrevocable prearranged funeral
97 or burial contract receives any public assistance benefits pursuant to this chapter and if the
98 purchaser of such contract or his or her successors in interest transfer, amend, or take any other
99 such actions regarding the contract so that any person will be entitled to a refund, such refund
100 shall be paid to the state of Missouri with any amount in excess of the public assistance benefits
101 provided under this chapter to be refunded by the state of Missouri to the purchaser or his or her
102 successors. In determining eligibility and the amount of benefits to be granted under federally
103 aided programs, the value of any life insurance policy where a seller or provider is made the
104 beneficiary or where the life insurance policy is assigned to a seller or provider, either being in
105 consideration for an irrevocable prearranged funeral contract under chapter 436, shall not be
106 taken into account or considered an asset of the beneficiary of the irrevocable prearranged funeral
107 contract.

108 5. In determining the total property owned pursuant to subdivision (5) of subsection 2
109 of this section, or resources, of any person claiming or for whom public assistance is claimed,
110 there shall be disregarded any life insurance policy, or prearranged funeral or burial contract, or
111 any two or more policies or contracts, or any combination of policies and contracts, which
112 provides for the payment of one thousand five hundred dollars or less upon the death of any of
113 the following:

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

115 (2) The spouse of a claimant or person for whom benefits are claimed with whom he or
116 she is living. If the value of such policies exceeds one thousand five hundred dollars, then the
117 total value of such policies may be considered in determining resources; except that, in the case
118 of temporary assistance for needy families, there shall be disregarded any prearranged funeral
119 or burial contract, or any two or more contracts, which provides for the payment of one thousand
120 five hundred dollars or less per family member.

121 6. Beginning September 30, 1989, when determining the eligibility of institutionalized
122 spouses, as defined in 42 U.S.C. Section 1396r-5, for medical assistance benefits as provided for
123 in section 208.151 and 42 U.S.C. Sections 1396a, et seq., the division of family services shall

124 comply with the provisions of the federal statutes and regulations. As necessary, the division
125 shall by rule or regulation implement the federal law and regulations which shall include but not
126 be limited to the establishment of income and resource standards and limitations. The division
127 shall require:

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

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

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

138 (4) That in the determination of initial eligibility of the institutionalized spouse, no
139 resources attributed to the community spouse shall be used in determining the eligibility of the
140 institutionalized spouse, except to the extent that the resources attributed to the community
141 spouse do exceed the community spouse's resource allowance as defined in 42 U.S.C. Section
142 1396r-5;

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

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

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

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

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

159 of the home and when the home shall be considered a resource that shall be considered in
160 determining eligibility.

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

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

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

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

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

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

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

18 (3) A child attending school full time;

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

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

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

38 [5.] **4.** The [division of family services] **department of social services** is authorized to
39 expend funds to provide child day care services, when appropriate, for the care of children
40 required by the absence of adult persons from the household due to [referral and participation
41 in employment, training, work incentive programs or special work projects] **work activities**.

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

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

6 (1) Inpatient hospital services, except to persons in an institution for mental diseases who
7 are under the age of sixty-five years and over the age of twenty-one years; provided that the MO
8 HealthNet division shall provide through rule and regulation an exception process for coverage
9 of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile
10 professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay
11 schedule; and provided further that the MO HealthNet division shall take into account through

12 its payment system for hospital services the situation of hospitals which serve a disproportionate
13 number of low-income patients;

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

21 (3) Laboratory and X-ray services;

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

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

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

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

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

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

55 (10) Home health care services;

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

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

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

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

84 fewest services. The rate paid to providers for each tier of service shall be set subject to
85 appropriations. Subject to appropriations, each resident of such facility who qualifies for
86 assistance under section 208.030 and meets the level of care required in this section shall, at a
87 minimum, if prescribed by a physician, be authorized up to one hour of personal care services
88 per day. Authorized units of personal care services shall not be reduced or tier level lowered
89 unless an order approving such reduction or lowering is obtained from the resident's personal
90 physician. Such authorized units of personal care services or tier level shall be transferred with
91 such resident if her or she transfers to another such facility. Such provision shall terminate upon
92 receipt of relevant waivers from the federal Department of Health and Human Services. If the
93 Centers for Medicare and Medicaid Services determines that such provision does not comply
94 with the state plan, this provision shall be null and void. The MO HealthNet division shall notify
95 the revisor of statutes as to whether the relevant waivers are approved or a determination of
96 noncompliance is made;

97 (15) Mental health services. The state plan for providing medical assistance under Title
98 XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental
99 health services when such services are provided by community mental health facilities operated
100 by the department of mental health or designated by the department of mental health as a
101 community mental health facility or as an alcohol and drug abuse facility or as a child-serving
102 agency within the comprehensive children's mental health service system established in section
103 630.097. The department of mental health shall establish by administrative rule the definition
104 and criteria for designation as a community mental health facility and for designation as an
105 alcohol and drug abuse facility. Such mental health services shall include:

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

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

116 (c) Rehabilitative mental health and alcohol and drug abuse services including home and
117 community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions
118 rendered to individuals in an individual or group setting by a mental health or alcohol and drug
119 abuse professional in accordance with a plan of treatment appropriately established,

120 implemented, monitored, and revised under the auspices of a therapeutic team as a part of client
121 services management. As used in this section, mental health professional and alcohol and drug
122 abuse professional shall be defined by the department of mental health pursuant to duly
123 promulgated rules. With respect to services established by this subdivision, the department of
124 social services, MO HealthNet division, shall enter into an agreement with the department of
125 mental health. Matching funds for outpatient mental health services, clinic mental health
126 services, and rehabilitation services for mental health and alcohol and drug abuse shall be
127 certified by the department of mental health to the MO HealthNet division. The agreement shall
128 establish a mechanism for the joint implementation of the provisions of this subdivision. In
129 addition, the agreement shall establish a mechanism by which rates for services may be jointly
130 developed;

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

134 (17) Beginning July 1, 1990, the services of a certified pediatric or family nursing
135 practitioner with a collaborative practice agreement to the extent that such services are provided
136 in accordance with chapters 334 and 335, and regulations promulgated thereunder;

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

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

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

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

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

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

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

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

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

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

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

185 (23) Blood clotting products-related services. For persons diagnosed with a bleeding
186 disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section
187 338.400, such services include:

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

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

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

195 (24) The MO HealthNet division shall, by January 1, 2008, and annually thereafter,
196 report the status of MO HealthNet provider reimbursement rates as compared to one hundred
197 percent of the Medicare reimbursement rates and compared to the average dental reimbursement
198 rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July
199 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare
200 reimbursement rates and for third-party payor average dental reimbursement rates. Such plan
201 shall be subject to appropriation and the division shall include in its annual budget request to the
202 governor the necessary funding needed to complete the four-year plan developed under this
203 subdivision.

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

209 (1) Dental services;

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

211 (3) Optometric services as defined in section 336.010;

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

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

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

227 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a
228 coordinated system of care for individuals with disabling impairments. Rehabilitation services
229 must be based on an individualized, goal-oriented, comprehensive and coordinated treatment
230 plan developed, implemented, and monitored through an interdisciplinary assessment designed
231 to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO
232 HealthNet division shall establish by administrative rule the definition and criteria for
233 designation of a comprehensive day rehabilitation service facility, benefit limitations and
234 payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010,
235 that is created under the authority delegated in this subdivision shall become effective only if it
236 complies with and is subject to all of the provisions of chapter 536 and, if applicable, section
237 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the
238 general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove
239 and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority
240 and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

241 3. The MO HealthNet division may require any participant receiving MO HealthNet
242 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July
243 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered
244 services except for those services covered under subdivisions (14) and (15) of subsection 1 of
245 this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title
246 XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder.
247 When substitution of a generic drug is permitted by the prescriber according to section 338.056,
248 and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not
249 lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of
250 the federal Social Security Act. A provider of goods or services described under this section
251 must collect from all participants the additional payment that may be required by the MO
252 HealthNet division under authority granted herein, if the division exercises that authority, to
253 remain eligible as a provider. Any payments made by participants under this section shall be in
254 addition to and not in lieu of payments made by the state for goods or services described herein
255 except the participant portion of the pharmacy professional dispensing fee shall be in addition
256 to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time
257 a service is provided or at a later date. A provider shall not refuse to provide a service if a
258 participant is unable to pay a required payment. If it is the routine business practice of a provider
259 to terminate future services to an individual with an unclaimed debt, the provider may include
260 uncollected co-payments under this practice. Providers who elect not to undertake the provision

261 of services based on a history of bad debt shall give participants advance notice and a reasonable
262 opportunity for payment. A provider, representative, employee, independent contractor, or agent
263 of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection
264 shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for
265 Medicare and Medicaid Services does not approve the Missouri MO HealthNet state plan
266 amendment submitted by the department of social services that would allow a provider to deny
267 future services to an individual with uncollected co-payments, the denial of services shall not be
268 allowed. The department of social services shall inform providers regarding the acceptability
269 of denying services as the result of unpaid co-payments.

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

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

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

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

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

291 9. Reimbursement rates to long-term care providers with respect to a total change in
292 ownership, at arm's length, for any facility previously licensed and certified for participation in
293 the MO HealthNet program shall not increase payments in excess of the increase that would
294 result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C.
295 1396a (a)(13)(C).

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

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

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

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