SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE FOR

SENATE BILL NO. 1007

95TH GENERAL ASSEMBLY

5096L.09C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 105.711, 148.340, 148.350, 148.370, 148.380, 172.850, 199.010, 199.200, 199.210, 199.230, 199.240, 199.250, 199.260, 208.010, 208.152, 208.215, 208.453, 208.895, 208.909, 208.918, and 660.300, RSMo, and to enact in lieu thereof twenty-seven new sections relating to public assistance programs administered by the state, with penalty provisions for a certain section and an emergency clause for certain sections.

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

Section A. Sections 105.711, 148.340, 148.350, 148.370, 148.380, 172.850, 199.010, 199.200, 199.210, 199.230, 199.240, 199.250, 199.260, 208.010, 208.152, 208.215, 208.453, 208.895, 208.909, 208.918, and 660.300, RSMo, are repealed and twenty-seven new sections enacted in lieu thereof, to be known as sections 105.012, 105.711, 148.340, 148.350, 148.370, 148.380, 172.850, 198.016, 199.010, 199.200, 199.210, 199.230, 199.240, 199.250, 199.260, 208.010, 208.027, 208.152, 208.215, 208.453, 208.895, 208.909, 208.918, 660.023, 660.300, 1, and 2, to read as follows:

105.012. 1. Before taking office and once every two years thereafter, all state elected officials, shall be subject to chemical testing of their blood or urine for the purpose of determining the drug content of the blood. The costs of such testing shall be paid by such official.

2. To be considered valid, chemical tests of the person's blood or urine shall be performed according to methods and devices approved by the state department of health and senior services, and shall be performed by licensed medical personnel or by a person possessing a valid permit issued by the state department of health and senior services for

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.

this purpose. A blood test shall not be performed if the medical personnel, in good faith medical judgment, believe such procedure would endanger the health of the person.

3. Upon request of the person tested, full information concerning the test shall be made available to the person.

4. Refusal to submit to a drug test as authorized under this section is an admission that the official has taken a controlled substance without legal authorization. An official who refuses to submit to a drug test under this section shall be subject to any sanction authorized by law or rule covering the respective official.

5. An official who tests positive for drugs that have not been lawfully prescribed or based on the testing has been shown to have abused the use of drugs that were otherwise lawfully prescribed shall participate in a drug treatment program. An official who tests positive for drugs under such circumstances and who fails to participate in a drug treatment program shall be subject to any sanction authorized by law or rule covering the respective official.

6. For purposes of this section, "drug" means marijuana, any narcotic drug or controlled substance as defined in chapter 195, RSMo, or the metabolite of any such substance.

7. No person administering a chemical test under this section or any other person, firm, or corporation with whom such person is associated shall be civilly liable for damages to the person tested except for negligence or by willful or wanton act or omission.

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

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

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

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

(3) (a) Any physician, psychiatrist, pharmacist, podiatrist, dentist, nurse, or other health care provider licensed to practice in Missouri under the provisions of chapter 330, 332, 334, 335,

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

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

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

(d) Any physician licensed pursuant to chapter 334, RSMo, who is affiliated with and receives no compensation from a nonprofit entity qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, which offers a free health screening in any setting or any physician, nurse, physician assistant, dental hygienist, dentist, **chiropractor,** or other health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, who provides health care services within the scope of his or her license or registration at a city or county health department organized under chapter 192, RSMo, or chapter 205, RSMo, a city health department operating under a city charter, or

a combined city-county health department, or a nonprofit community health center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, if such services are restricted to primary care**, health care services provided by a specialist,** and preventive health services, provided that such services shall not include the performance of an abortion, and if such health services are provided by the health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, without compensation. MO HealthNet or Medicare payments for primary care**, health care services provided by a specialist,** and preventive health services provided by **a specialist or** a health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, who volunteers at a free health clinic is not compensation for the purpose of this section if the total payment is assigned to the free health clinic. For the purposes of the section, "free health clinic" means a nonprofit community health center qualified as exempt from federal taxation under Section 501 (c)(3) of the Internal Revenue Code of 1987, as amended, that provides primary care**, health care services provided by a specialist,** and preventive health services to people without health insurance coverage for the services provided without charge. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars, for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars. Liability or malpractice insurance obtained and maintained in force by or on behalf of any **specialist or** health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, shall not be considered available to pay that portion of a judgment or claim for which the state legal expense fund is liable under this paragraph;

(e) Any physician, nurse, physician assistant, dental hygienist, or dentist licensed or registered to practice medicine, nursing, or dentistry or to act as a physician assistant or dental hygienist in Missouri under the provisions of chapter 332, 334, or 335, RSMo, or lawfully practicing, who provides medical, nursing, or dental treatment within the scope of his **or her** license or registration to students of a school whether a public, private, or parochial elementary or secondary school or summer camp, if such physician's treatment is restricted to primary care and preventive health services and if such medical, dental, or nursing services are provided by the physician, dentist, physician assistant, dental hygienist, or nurse without compensation. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars, for all claims arising out of and judgments based upon the same act or acts alleged in a

single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars; **[**or**]**

(f) Any physician licensed under chapter 334, RSMo, **and such physician's professional corporation organized under chapter 356, or hospital when the physician is directly employed by a hospital,** or dentist licensed under chapter 332, RSMo, **and any licensed health care professional under the direction of a licensed physician or dentist** providing medical care without compensation to an individual referred to his or her care by a city or county health department organized under chapter 192 or 205, RSMo, a city health department operating under a city charter, or a combined city-county health department, or nonprofit health center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or a federally funded community health center organized under Section 315, 329, 330, or 340 of the Public Health Services Act, 42 U.S.C. Section 216, 254c**, or a charitable health care referral network qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended**; provided that such treatment shall not include the performance of an abortion. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of one million dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed one million dollars for any one claimant, and insurance policies purchased under the provisions of section 105.721 shall be limited to one million dollars. Liability or malpractice insurance obtained and maintained in force by or on behalf of any physician licensed under chapter 334, RSMo, or any dentist licensed under chapter 332, RSMo, shall not be considered available to pay that portion of a judgment or claim for which the state legal expense fund is liable under this paragraph;

(g) Free health clinics defined as a nonprofit health center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or a charitable health care referral network qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and any social welfare board created under section 205.770;

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

(5) Any attorney licensed to practice law in the state of Missouri who practices law at or through a nonprofit community social services center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or through any agency of any federal, state, or local government, if such legal practice is provided by the attorney without compensation. In the case of any claim or judgment that arises under this

subdivision, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars; or

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

3. The department of health and senior services shall promulgate rules regarding contract procedures and the documentation of care provided under paragraphs (b), (c), (d), (e), and (f) of subdivision (3) of subsection 2 of this section. The limitation on payments from the state legal expense fund or any policy of insurance procured pursuant to the provisions of section 105.721, provided in subsection 7 of this section, shall not apply to any claim or judgment arising under paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section. Any claim or judgment arising under paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section shall be paid by the state legal expense fund or any policy of insurance procured pursuant to section 105.721, to the extent damages are allowed under sections 538.205 to 538.235, RSMo. Liability or malpractice insurance obtained and maintained in force by any health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, for coverage concerning his or her private practice and assets shall not be considered available under subsection 7 of this section to pay that portion of a judgment or claim for which the state legal expense fund is liable under paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section. However, a health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, may purchase liability or malpractice insurance for coverage of liability claims or judgments based upon care rendered under paragraphs (c), (d), (e), and (f) of subdivision (3) of subsection 2 of this section which exceed the amount of liability coverage provided by the state legal expense fund under those paragraphs. Even if paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section is repealed or modified, the state legal expense fund shall be available for damages which occur while the pertinent paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section is in effect.

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

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

(1) Economic damages to any one claimant; and

(2) Up to three hundred fifty thousand dollars for noneconomic damages. The state legal expense fund shall be the exclusive remedy and shall preclude any other civil actions or proceedings for money damages arising out of or relating to the same subject matter against the state officer or employee, or the officer's or employee's estate. No officer or employee of the state or any agency of the state shall be individually liable in his or her personal capacity for conduct of such officer or employee arising out of and performed in connection with his or her official duties on behalf of the state or any agency of the state. The provisions of this subsection

shall not apply to any defendant who is not an officer or employee of the state or any agency of the state in any proceeding against an officer or employee of the state or any agency of the state. Nothing in this subsection shall limit the rights and remedies otherwise available to a claimant under state law or common law in proceedings where one or more defendants is not an officer or employee of the state or any agency of the state.

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

7. Except as provided in subsection 3 of this section, in the case of any claim or judgment that arises under sections 537.600 and 537.610, RSMo, against the state of Missouri, or an agency of the state, the aggregate of payments from the state legal expense fund and from any policy of insurance procured pursuant to the provisions of section 105.721 shall not exceed the limits of liability as provided in sections 537.600 to 537.610, RSMo. No payment shall be made from the state legal expense fund or any policy of insurance procured with state funds pursuant to section 105.721 unless and until the benefits provided to pay the claim by any other policy of liability insurance have been exhausted.

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

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

148.340. **1.** Every insurance company or association not organized under the laws of this state, shall, as provided in section 148.350, quarterly pay tax upon the direct premiums received, whether in cash or in notes, in this state or on account of business done in this state, for insurance

of life, property or interest in this state at the rate of two percent per annum in lieu of all other taxes, except as in sections 148.310 to 148.461 otherwise provided, which amount of taxes shall be assessed and collected as herein provided; provided, that fire and casualty insurance companies or associations shall be credited with canceled or return premiums actually paid during the year in this state, and that life insurance companies shall be credited with dividends actually declared to policyholders in this state, but held by the company and applied to the reduction of premiums payable by the policyholder.

2. Every health maintenance organization under contract with the state of Missouri to provide services to recipients of medical assistance, not organized under the laws of this state, shall quarterly pay tax upon the direct premiums received, with such payment to be on the same terms as the insurance companies and associations described in subsection 1 of this section. Such tax shall be in addition to any other tax levied by the state. This subsection shall apply only as long as the revenues generated under this subsection are eligible for federal financial participation and payments. For the purposes of this subsection, "federal financial participation" means the federal government's share of Missouri's expenditures under the Medicaid program. This subsection shall expire June 30, 2012.

148.350. 1. Every such company or association shall, on or before the first day of March in each year, make a return, verified by the affidavit of its president and secretary or other authorized officers, to the director of the department of insurance, financial institutions and professional registration stating the amount of all premiums received on account of policies issued in this state by such company, whether in cash or in notes, during the year ending on the thirty-first day of December, next preceding. Upon receipt of such returns, the director of the department of insurance, financial institutions and professional registration shall verify the same and certify the amount of tax due from the various companies on the basis and at the rate provided in section 148.340, and shall certify the same to the director of revenue together with the amount of the quarterly installments to be made as provided in subsection 2 of this section, on or before the thirtieth day of April of each year.

2. Beginning January 1, 1983, the amount of the tax due for that calendar year and each succeeding calendar year thereafter shall be paid in four approximately equal estimated quarterly installments and a fifth reconciling installment. The first four installments shall be based upon the tax assessed for the immediately preceding taxable year ending on the thirty-first day of December, next preceding. The quarterly installment shall be made on the first day of March, the first day of June, the first day of September, and the first day of December. Immediately after receiving from the director of the department of insurance, financial institutions and professional registration, certification of the amount of tax due from the various companies, the director of

revenue shall notify and assess each company the amount of taxes on its premiums for the calendar year ending on the thirty-first day of December, next preceding. The director of revenue shall also notify and assess each company the amount of the estimated quarterly installments to be made for the calendar year. If the amount of the actual tax due for any year exceeds the total of the installments made for such year, the balance of the tax due shall be paid on the first day of June of the following year, together with the regular quarterly installment due at that time. If the total amount of the tax actually due is less than the total amount of the installments actually paid, the amount by which the amount paid exceeds the amount due shall be credited against the tax for the following year and deducted from the quarterly installment otherwise due on the first day of June. If the March first quarterly installment made by a company is less than the amount assessed by the director of revenue, the difference will be due on June first, but no interest will accrue to the state on the difference unless the amount paid by the company is less than eighty percent of one-fourth of the total amount of tax assessed by the director of revenue for the immediately preceding taxable year. If the estimated quarterly tax installments are not so paid, the director of revenue shall certify such fact to the director of the department of insurance, financial institutions and professional registration who shall thereafter suspend such delinquent company or companies from the further transaction of business in this state until such taxes shall be paid, and such companies shall be subject to the provisions of sections 148.410 to 148.461.

3. **Except as provided in subsection 4 of this section,** upon receiving such money from the director of revenue, the state treasurer shall receipt one-half thereof into the general revenue fund of the state, and he shall place the remainder of such tax to the credit of a fund to be known as "The County Foreign Insurance Tax Fund", which is hereby created and established. All premium tax credits described in sections 135.500 to 135.529, RSMo, shall only reduce the amount of moneys received by the general revenue fund of this state and shall not reduce any moneys received by the county foreign insurance tax fund.

4. (1) Taxes collected from health maintenance organizations under subsection 2 of section 148.340 shall be deposited to the credit of the "Managed Care Fund", which is hereby created and established in the state treasury.

(2) The state treasurer shall be custodian of the fund and may approve disbursements from the fund in accordance with sections 30.170 and 30.180. The unexpended balance in the managed care fund at the end of the biennium is exempt from the provisions of section 33.080. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

148.370. **1.** Every insurance company or association organized under the laws of the state of Missouri and doing business under the provisions of sections 376.010 to 376.670,

379.205 to 379.310, 379.650 to 379.790 and chapter 381, RSMo, and every mutual fire insurance company organized under the provisions of sections 379.010 to 379.190, RSMo, shall, as hereinafter provided, quarterly pay, beginning with the year 1983, a tax upon the direct premiums received by it from policyholders in this state, whether in cash or in notes, or on account of business done in this state, in lieu of the taxes imposed under the provisions of chapters 143 and 147, RSMo, for insurance of life, property or interest in this state, at the rate of two percent per annum, which amount of taxes shall be assessed and collected as hereinafter provided; provided, that fire and casualty insurance companies or associations shall be credited with canceled or returned premiums actually paid during the year in this state, and that life insurance companies shall be credited with dividends actually declared to policyholders in this state but held by the company and applied to the reduction of premiums payable by the policyholder.

2. Every health maintenance organization organized under the laws of this state that is under contract with the state of Missouri to provide services to recipients of medical assistance shall quarterly pay tax upon the direct premiums received, with such payment to be on the same terms as the insurance companies and associations described in subsection 1 of this section. Such tax shall be in addition to any other tax levied by the state. This subsection shall apply only as long as the revenues generated under this subsection are eligible for federal financial participation and payments. For the purposes of this subsection, "federal financial participation" means the federal government's share of Missouri's expenditures under the Medicaid program. This subsection shall expire June 30, 2012.

148.380. 1. Every such company, on or before the first day of March in each year, shall make a return verified by the affidavit of its president and secretary, or other chief officers, to the director of the department of insurance, financial institutions and professional registration, stating the amount of all direct premiums received by it from policyholders in this state, whether in cash or in notes, during the year ending on the thirty-first day of December, next preceding. Upon receipt of such returns the director of the department of insurance, financial institutions and professional registration shall verify the same and certify the amount of the tax due from the various companies on the basis and at the rate provided in section 148.370, taking into consideration deductions and credits allowed by law, and shall certify the same to the director of revenue together with the amount of the quarterly installments to be made as provided in subsection 2 of this section, on or before the thirtieth day of April of each year.

2. Beginning January 1, 1983, the amount of the tax due for that calendar year and each succeeding calendar year thereafter shall be paid in four approximately equal estimated quarterly installments, and a fifth reconciling installment. The first four installments shall be based upon the tax for the immediately preceding taxable year ending on the thirty-first day of December,

next preceding. The quarterly installments shall be made on the first day of March, the first day of June, the first day of September and the first day of December. Immediately after receiving certification from the director of the department of insurance, financial institutions and professional registration of the amount of tax due from the various companies, the director of revenue shall notify and assess each company the amount of taxes on its premiums for the calendar year ending on the thirty-first day of December, next preceding. The director of revenue shall also notify and assess each company the amount of the estimated quarterly installments to be made for the calendar year. If the amount of the actual tax due for any year exceeds the total of the installments made for such year, the balance of the tax due shall be paid on the first day of June of the year following, together with the regular quarterly payment due at that time. If the total amount of the tax actually due is less than the total amount of the installments actually paid, the amount by which the amount paid exceeds the amount due shall be credited against the tax for the following year and deducted from the quarterly installment otherwise due on the first day of June. If the March first quarterly installment made by a company is less than the amount assessed by the director of revenue, the difference will be due on June first, but no interest will accrue to the state on the difference unless the amount paid by the company is less than eighty percent of one-fourth of the total amount of tax assessed by the director of revenue for the immediately preceding taxable year.

3. If the estimated quarterly tax installments are not so paid, the director of revenue shall notify the director of the department of insurance, financial institutions and professional registration who shall thereupon suspend such delinquent company from the further transaction of business in this state until such taxes shall be paid, and such companies shall be subject to the provisions of sections 148.410 to 148.461.

4. **Except as provided in subsection 5 of this section,** upon receipt of the money the state treasurer shall receipt one-half thereof into the general revenue fund of the state, and one-half thereof to the credit of the county foreign insurance fund for the purposes set forth in section 148.360.

5. Taxes collected from health maintenance organizations under subsection 2 of section 148.370 shall be to the credit of the managed care fund, established under section 148.350.

172.850. The Missouri rehabilitation center may be transferred to the curators of the University of Missouri from the department of health and senior services by agreement between the state department of health and senior services and the board of curators. It is the intent of the general assembly that the University of Missouri shall continue to carry out the functions of the center consistent with statutory purposes as set forth in **[**sections**]** **section** 199.010 **[**to 199.270,

RSMo**]**, with such reservation as may be specified by the parties pertaining to the department's continuing control of the tuberculosis testing laboratory.

198.016. Prior to admission of a MO HealthNet individual into a long-term care facility, the prospective resident or his or her next of kin, legally authorized representative, or designee shall be informed of the home and community based services available in this state and shall have on record that such home and community based services have been declined as an option.

199.010. The curators of the University of Missouri shall provide for the care of persons needing head injury and other rehabilitation **[**and further,**]** **subject to appropriation by the general assembly. The department of health and senior services shall provide** for the treatment and commitment of persons having tuberculosis subject to appropriation by the general assembly.

199.200. 1. Upon filing of the petition, the court shall set the matter down for a hearing either during term time or in vacation, which time shall be not less than five days nor more than fifteen days subsequent to filing. A copy of the petition together with summons stating the time and place of hearing shall be served upon the person three days or more prior to the time set for the hearing. Any X-ray picture and report of any written report relating to sputum examinations certified by the department of health and senior services or local board shall be admissible in evidence without the necessity of the personal testimony of the person or persons making the examination and report.

2. The prosecuting attorney or the city attorney shall act as legal counsel for their respective local boards in this proceeding and such authority is hereby granted. The court shall appoint legal counsel for the individual named in the petition if requested to do so if such individual is unable to employ counsel.

3. All court costs incurred in proceedings under sections 199.170 to 199.270, including examinations required by order of the court but excluding examinations procured by the person named in the petition, shall be borne by the county in which the proceedings are brought.

4. Summons shall be served by the sheriff of the county in which proceedings under sections 199.170 to 199.270 are initiated and return thereof shall be made as in other civil cases.

5. Upon the filing of an ex parte petition for emergency temporary commitment pursuant to subsection 3 of section 199.180, the court shall hear the matter within ninety-six hours of such filing. The local board shall have the authority to detain the individual named in the petition pending the court's ruling on the ex parte petition for emergency temporary commitment. If the petition is granted, the individual named in the petition shall be confined in a facility designated by the **[**curators of the University of Missouri**]** **department of health and senior services** in

accordance with section 199.230 until a full hearing pursuant to subsections 1 to 4 of this section is held.

199.210. 1. Upon the hearing set in the order, the individual named in the order shall have a right to be represented by counsel, to confront and cross-examine witnesses against him, and to have compulsory process for the securing of witnesses and evidence in his own behalf. The court may in its discretion call and examine witnesses and secure the production of evidence in addition to that adduced by the parties; such additional witnesses being subject to cross-examination by either or both parties.

2. Upon a consideration of the petition and evidence, if the court finds that the person named in the petition is a potential transmitter and conducts himself so as to be a danger to the public health, an order shall be issued committing the individual named in the petition to a facility designated by the **[**curators of the University of Missouri**] department of health and senior services** and directing the sheriff to take him into custody and deliver him to the facility. If the court does not so find, the petition shall be dismissed. The cost of transporting the person to the facility designated by the **[**curators of the University of Missouri**] department of health and senior services** shall be paid out of general county funds.

199.230. Upon commitment, the patient shall be confined in a facility designated by the **[**curators of the University of Missouri**] department of health and senior services** until such time as **[**the director of the facility determines that the patient no longer has active tuberculosis or that**]** the patient's discharge will not endanger public health.

199.240. No person committed to a facility designated by the **[**curators of the University of Missouri**] department of health and senior services** under sections 199.170 to 199.270 shall be required to submit to medical or surgical treatment without his consent, or, if incapacitated, without the consent of his legal guardian, or, if a minor, without the consent of a parent or next of kin.

199.250. 1. The department of health and senior services may**[**, by agreement with the curators of the University of Missouri,**]** contract for such facilities at the Missouri rehabilitation center as are necessary to carry out the functions of **[**the tuberculosis testing laboratory and may employ personnel as are necessary for the operation of such laboratory**] sections 199.010 to 199.350**. **Such contracts shall be exempt from the competitive bidding requirements of chapter 34.**

2. **[**The expenses incurred in the operation of the tuberculosis testing laboratory at the rehabilitation center or elsewhere shall be paid from state or federal or other funds appropriated for the maintenance and operation of the tuberculosis testing laboratory**] State payment shall be available for the treatment and care of individuals committed under section 199.210 only after benefits from all third-party payers have been exhausted**.

199.260. Any person committed under the provisions of sections 199.170 to 199.270 who leaves the facility designated by the **[**curators of the University of Missouri**] department of health and senior services** without having been discharged by the director of the facility or other officer in charge or by order of court shall be taken into custody and returned thereto by the sheriff of any county where such person may be found, upon an affidavit being filed with the sheriff by the director of the facility, or duly authorized officer in charge thereof, to which the person had been committed.

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 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 division of family services 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 division of family services 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 pursuant to

subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, 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 division of family services, 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 division of family services 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 pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, 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 division of family services to sell such property and from the net proceeds of the sale repay the amount of assistance received during such period. If the property has not been sold within six months, or if eligibility terminates for any other reason, the entire amount of assistance paid during such period shall be a debt due the state;

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

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

4. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the value of burial lots or any amounts placed in an irrevocable prearranged funeral or burial contract pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, 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, RSMo, and any memorial, monument, marker, tombstone or letter marking a burial space. If the beneficiary, as defined in chapter 436, RSMo, 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 cancel or amend the contract so that any person will be entitled to a refund, such refund shall be paid to the state

of Missouri up to the amount of public assistance benefits provided pursuant to this chapter with any remainder to be paid to those persons designated in chapter 436, RSMo.

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 division of family services 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 division of family services 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 division of family services 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.

208.027. 1. The department of social services shall develop a program to screen each work-eligible applicant or work-eligible recipient who is otherwise eligible for temporary assistance for needy families benefits under this chapter and then test each

applicant or recipient who the department has reasonable suspicion to believe, based on the screening, engages in illegal use of controlled substances. Any applicant or recipient who refuses to participate in the testing process shall be declared ineligible for temporary assistance for needy families benefits for a period of one year. Any applicant or recipient who is found to have tested positive for the illegal use of a controlled substance, which was not prescribed for such applicant or recipient by a licensed health care provider, 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 one year from the date of the administrative hearing decision. 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.

2. By July 1, 2011, 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, 2010, shall be invalid and void.

3. By September 30, 2010, the department of social services shall develop, distribute to its staff, implement, and begin enforcement of a policy that any department employee who fails to report the suspected illegal use of a controlled substance under the program developed under subsection 1 of this section, or the suspected fraudulent reporting of total household size or income under the temporary assistance for needy families program, by any recipient or potential recipient, shall be subject to immediate termination of employment.

4. Beginning July 1, 2011, and annually thereafter, the department shall track and report to the general assembly the total number of reported incidents of suspected illegal drug use and of suspected fraudulent reporting of total household size or income, and the overall results of the program developed under this section and of fraud prosecutions made for fraud violations of the temporary assistance for needy families eligibility rules.

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) **Diabetic education and initial diabetic management training services. Such services shall be limited to two visits for diabetic training that shall include an initial consultation and one follow-up visit;**

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

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

[(9)**] (10)** 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)**] (11)** Home health care services;

[(11)**] (12)** 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)**] (13)** 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)**] (14)** 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)**] (15)** 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, RSMo, 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)**] (16)** 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, RSMo. 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)**] (17)** 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)**] (18)** Beginning July 1, 1990, the services of a certified pediatric or family nursing practitioner with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, RSMo, and regulations promulgated thereunder;

[(18)**] (19)** 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)**] (20)** 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)**] (21)** 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);

[(21)**] (22)** 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)**] (23)** 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)**] (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, RSMo;

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

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

(5) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to

an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

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

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, RSMo, 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, RSMo, as MO HealthNet personal care providers.

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

208.215. 1. MO HealthNet is payer of last resort unless otherwise specified by law. When any person, corporation, institution, public agency or private agency is liable, either pursuant to contract or otherwise, to a participant receiving public assistance on account of personal injury to or disability or disease or benefits arising from a health insurance plan to which the participant may be entitled, payments made by the department of social services or MO HealthNet division shall be a debt due the state and recoverable from the liable party or participant for all payments made **[**in**] on** behalf of the participant and the debt due the state shall not exceed the payments made from MO HealthNet benefits provided under sections 208.151 to 208.158 and section 208.162 and section 208.204 on behalf of the participant, minor or estate for payments on account of the injury, disease, or disability or benefits arising from a health insurance program to which the participant may be entitled. **Any health benefit plan as defined in section 376.1350, third party administrator, administrative service organization, and pharmacy benefits manager, shall process and pay all properly submitted medical assistance subrogation claims or MO HealthNet subrogation claims:**

(1) For a period of three years from the date services were provided or rendered; however, an entity:

(a) Shall not be required to reimburse for items or services which are not covered under MO HealthNet;

(b) Shall not deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form, failure to present proper documentation of coverage at the point of sale, or failure to provide prior authorization;

(c) Shall not be required to reimburse for items or services for which a claim was previously submitted to the health benefit plan, third party administrator, administrative service organization, or pharmacy benefits manager by the health care provider or the participant and the claim was properly denied by the health benefit plan, third-party administrator, administrative service organization, or pharmacy benefits manager for procedural reasons, except for timely filing, type or format of the claim form, failure to

present proper documentation of coverage at the point of sale, or failure to obtain prior authorization;

(d) Shall not be required to reimburse for items or services which are not covered under or were not covered under the plan offered by the entity against which a claim for subrogation has been filed; and

(e) Shall reimburse for items or services to the same extent that the entity would have been liable as if it had been properly billed at the point of sale and the amount due is limited to what the entity would have paid as if it had been properly billed at the point of sale; and

(2) If any action by the state to enforce its rights with respect to such claim is commenced within six years of the state's submission of such claim.

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

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

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

208.162 and 208.204. A **[**recipient**] participant** who has notice or who has actual knowledge of the department's rights to third-party benefits who receives any third-party benefit or proceeds for a covered illness or injury is either required to pay the division within sixty days after receipt of settlement proceeds the full amount of the third-party benefits up to the total MO HealthNet benefits provided or to place the full amount of the third-party benefits in a trust account for the benefit of the division pending judicial or administrative determination of the division's right to third-party benefits.

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

6. Every participant, minor, guardian, conservator, personal representative, estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful death, or his attorney or legal representative shall promptly notify the MO HealthNet division of any recovery from a third party and shall immediately reimburse the department of social services, MO HealthNet division, or its contractor from the proceeds of any settlement, judgment, or other recovery in any action or claim initiated against any such third party. A judgment, award, or settlement in an action by a **[**recipient**] participant** to recover damages for injuries or other third-party benefits in which the division has an interest may not be satisfied without first giving the division notice and a reasonable opportunity to file and satisfy the claim or proceed with any action as otherwise permitted by law.

7. The department of social services, MO HealthNet division or its contractor shall have a right to recover the amount of payments made to a provider under this chapter because of an injury, disease, or disability, or benefits arising from a health insurance plan to which the participant may be entitled for which a third party is or may be liable in contract, tort or otherwise under law or equity. Upon request by the MO HealthNet division, all third-party payers shall provide the MO HealthNet division with information contained in a 270/271 Health Care Eligibility Benefits Inquiry and Response standard transaction mandated under the federal Health Insurance Portability and Accountability Act, except that third-party payers shall not

include accident-only, specified disease, disability income, hospital indemnity, or other fixed indemnity insurance policies.

8. The department of social services or MO HealthNet division shall have a lien upon any moneys to be paid by any insurance company or similar business enterprise, person, corporation, institution, public agency or private agency in settlement or satisfaction of a judgment on any claim for injuries or disability or disease benefits arising from a health insurance program to which the participant may be entitled which resulted in medical expenses for which the department or MO HealthNet division made payment. This lien shall also be applicable to any moneys which may come into the possession of any attorney who is handling the claim for injuries, or disability or disease or benefits arising from a health insurance plan to which the participant may be entitled which resulted in payments made by the department or MO HealthNet division. In each case, a lien notice shall be served by certified mail or registered mail, upon the party or parties against whom the applicant or participant has a claim, demand or cause of action. The lien shall claim the charge and describe the interest the department or MO HealthNet division has in the claim, demand or cause of action. The lien shall attach to any verdict or judgment entered and to any money or property which may be recovered on account of such claim, demand, cause of action or suit from and after the time of the service of the notice.

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

(1) The amount of the charge sought to be enforced against the recovery when expressed as a percentage of the gross amount of the recovery; the amount of the charge sought to be enforced against the recovery when expressed as a percentage of the amount obtained by subtracting from the gross amount of the recovery the total attorney's fees and other costs incurred by the participant incident to the recovery; and whether the department should, as a matter of fairness and equity, bear its proportionate share of the fees and costs incurred to generate the recovery from which the charge is sought to be satisfied;

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

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

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

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

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

10. The burden of producing evidence sufficient to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking such reduction. **The computerized records of the MO HealthNet division, certified by the director or his designee, shall be prima facie evidence of proof of moneys expended and the amount of the debt due the state.**

11. The court may reduce and apportion the department's or MO HealthNet division's lien proportionate to the recovery of the claimant. The court may consider the nature and extent of the injury, economic and noneconomic loss, settlement offers, comparative negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs. The department or MO HealthNet division shall pay its pro rata share of the attorney's fees based on the department's or MO HealthNet division's lien as it compares to the total settlement agreed upon. This section shall not affect the priority of an attorney's lien under section 484.140, RSMo. The charges of the department or MO HealthNet division or contractor described in this section, however, shall take priority over all other liens and charges existing under the laws of the state of Missouri with the exception of the attorney's lien under such statute.

12. Whenever the department of social services or MO HealthNet division has a statutory charge under this section against a recovery for damages incurred by a participant because of its advancement of any assistance, such charge shall not be satisfied out of any recovery until the attorney's claim for fees is satisfied, **[**irrespective**] regardless** of whether **[**or not**]** an action based

on participant's claim has been filed in court. Nothing herein shall prohibit the director from entering into a compromise agreement with any participant, after consideration of the factors in subsections 9 to 13 of this section.

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

(1) The lien shall be for the debt due the state for MO HealthNet benefits paid or to be paid on behalf of a participant. The amount of the lien shall be for the full amount due the state at the time the lien is enforced;

(2) The MO HealthNet division shall file for record, with the recorder of deeds of the county in which any real property of the participant is situated, a written notice of the lien. The notice of lien shall contain the name of the participant and a description of the real estate. The recorder shall note the time of receiving such notice, and shall record and index the notice of lien in the same manner as deeds of real estate are required to be recorded and indexed. The director or the director's designee may release or discharge all or part of the lien and notice of the release shall also be filed with the recorder. The department of social services, MO HealthNet division, shall provide payment to the recorder of deeds the fees set for similar filings in connection with the filing of a lien and any other necessary documents;

(3) No such lien may be imposed against the property of any individual prior to the individual's death on account of MO HealthNet benefits paid except:

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

a. Who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving

services in such institution, to spend for costs of medical care all but a minimal amount of his or her income required for personal needs; and

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

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

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

(a) The spouse of such individual;

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

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

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

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

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

16. All participants receiving benefits as defined in this chapter shall cooperate with the state by reporting to the family support division or the MO HealthNet division, within thirty days, any occurrences where an injury to their persons or to a member of a household who receives MO HealthNet benefits is sustained, on such form or forms as provided by the family support division or MO HealthNet division.

17. If a person fails to comply with the provision of any judicial or administrative decree or temporary order requiring that person to maintain medical insurance on or be responsible for medical expenses for a dependent child, spouse, or ex-spouse, in addition to other remedies available, that person shall be liable to the state for the entire cost of the medical care provided

pursuant to eligibility under any public assistance program on behalf of that dependent child, spouse, or ex-spouse during the period for which the required medical care was provided. Where a duty of support exists and no judicial or administrative decree or temporary order for support has been entered, the person owing the duty of support shall be liable to the state for the entire cost of the medical care provided on behalf of the dependent child or spouse to whom the duty of support is owed.

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

(1) Actual and legal issues of liability as may exist between the **[**recipient**] participant** and the liable party;

(2) Total funds available for settlement; and

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

208.453. Every hospital as defined by section 197.020, RSMo, except **[**public hospitals which are operated primarily for the care and treatment of mental disorders and**]** any hospital operated by the department of health and senior services, shall, in addition to all other fees and taxes now required or paid, pay a federal reimbursement allowance for the privilege of engaging in the business of providing inpatient health care in this state. For the purpose of this section, the phrase "engaging in the business of providing inpatient health care in this state" shall mean accepting payment for inpatient services rendered. The federal reimbursement allowance to be paid by a hospital which has an unsponsored care ratio that exceeds sixty-five percent or hospitals owned or operated by the board of curators, as defined in chapter 172, RSMo, may be eliminated by the director of the department of social services. The unsponsored care ratio shall be calculated by the department of social services.

208.895. 1. Upon receipt of a properly completed referral for MO HealthNet-funded home- and community-based care containing a nurse assessment or physician's order, the department of health and senior services **[**shall**] may**:

(1) Review the recommendations regarding services and process the referral within fifteen business days;

(2) Issue a prior-authorization for home and community-based services when information contained in the referral is sufficient to establish eligibility for MO HealthNet-

funded long-term care and determine the level of service need as required under state and federal regulations;

(3) Arrange for the provision of services by an in-home provider;

(4) Reimburse the in-home provider for one nurse visit to conduct an assessment and recommendation for a care plan and, where necessary based on case circumstances, a second nurse visit may be authorized to gather additional information or documentation necessary to constitute a completed referral;

(5) Notify the referring entity upon the authorization of MO HealthNet eligibility and provide MO HealthNet reimbursement for personal care benefits effective the date of the assessment or physician's order, and MO HealthNet reimbursement for waiver services effective the date the state reviews and approves the care plan;

(6) Notify the referring entity within five business days of receiving the referral if additional information is required to process the referral; and

(7) Inform the provider and contact the individual when information is insufficient or the proposed care plan requires additional evaluation by state staff that is not obtained from the referring entity to schedule an in-home assessment to be conducted by the state staff within thirty days.

2. **The department of health and senior services may contract for initial home and community-based assessments, including a care plan, through an independent third-party assessor. The contract shall include a requirement that:**

(1) All home and community-based assessments shall be conducted by the third-party assessor face-to-face with the patient receiving the assessment. Assessments by telephone shall not be permitted;

(2) Within fifteen days of receipt of a referral for service, the contractor shall have made an assessment of care need and developed a plan of care; and

(3) The contractor notify the referring entity within five days of receipt of referral if additional information is needed to process the referral.

The contract shall also include the same requirements for such assessments as of January 1, 2010, related to timeliness of assessments and the beginning of service. The contract shall be bid under chapter 34 and shall not be a risk-based contract.

3. **The two nurse visits authorized by subsection 16 of section 660.300 shall continue to be performed by home and community-based providers for, including but not limited to, reassessment and level of care recommendations. These reassessments and care plan changes shall be reviewed and approved by the independent third party assessor. In the**

event of dispute over the level of care required, the third party assessor shall conduct a face-to-face review with the client in question.

208.909. 1. Consumers receiving personal care assistance services shall be responsible for:

(1) Supervising their personal care attendant;

(2) Verifying wages to be paid to the personal care attendant;

(3) Preparing and submitting time sheets, signed by both the consumer and personal care attendant, to the vendor on a biweekly basis;

(4) Promptly notifying the department within ten days of any changes in circumstances affecting the personal care assistance services plan or in the consumer's place of residence; **[**and**]**

(5) Reporting any problems resulting from the quality of services rendered by the personal care attendant to the vendor. If the consumer is unable to resolve any problems resulting from the quality of service rendered by the personal care attendant with the vendor, the consumer shall report the situation to the department**; and**

(6) Providing the vendor with all necessary information to complete required paperwork for establishing the employer identification number.

2. Participating vendors shall be responsible for:

(1) Collecting time sheets **or reviewing reports of delivered services** and certifying **[**their**]** **the** accuracy **thereof**;

(2) The Medicaid reimbursement process, including the filing of claims and reporting data to the department as required by rule;

(3) Transmitting the individual payment directly to the personal care attendant on behalf of the consumer;

(4) Monitoring the performance of the personal care assistance services plan.

3. No state or federal financial assistance shall be authorized or expended to pay for services provided to a consumer under sections 208.900 to 208.927, if the primary benefit of the services is to the household unit, or is a household task that the members of the consumer's household may reasonably be expected to share or do for one another when they live in the same household, unless such service is above and beyond typical activities household members may reasonably provide for another household member without a disability.

4. No state or federal financial assistance shall be authorized or expended to pay for personal care assistance services provided by a personal care attendant who is listed on any of the background check lists in the family care safety registry under sections 210.900 to 210.937, RSMo, unless a good cause waiver is first obtained from the department in accordance with section 660.317, RSMo.

5. (1) All vendors shall, by July 1, 2015, have, maintain, and use a telephone tracking system for the purpose of reporting and verifying the delivery of consumer-directed services as authorized by the department of health and senior services or its designee. Use of such a system prior to July 1, 2015, shall be voluntary. The telephone tracking system shall be used to process payroll for employees and for submitting claims for reimbursement to the MO HealthNet division. At a minimum, the telephone tracking system shall:

(a) Record the exact date services are delivered;

(b) Record the exact time the services begin and exact time the services end;

(c) Verify the telephone number from which the services are registered;

(d) Verify that the number from which the call is placed is a telephone number unique to the client;

(e) Require a personal identification number unique to each personal care attendant; and

(f) Be capable of producing reports of services delivered, tasks performed, client identity, beginning and ending times of service and date of service in summary fashion that constitute adequate documentation of service;

(g) Be capable of producing reimbursement requests for consumer approval that assures accuracy and compliance with program expectations for both the consumer and vendor.

(2) The department of health and senior services, in collaboration with other appropriate agencies, including centers for independent living, shall establish telephone tracking system pilot projects, implemented in two regions of the state, with one in an urban area and one in a rural area. Each pilot project shall meet the requirements of this section and section 208.918. The department of health and senior services shall, by December 31, 2013, submit a report to the governor and general assembly detailing the outcomes of these pilot projects. The report shall take into consideration the impact of a telephone tracking system on the quality of the services delivered to the consumer and the principles of self-directed care.

(3) As new technology becomes available, the department may allow use of a more advanced tracking system, provided that such system is at least as capable of meeting the requirements of this subsection.

(4) The department of health and senior services shall promulgate by rule the minimum necessary criteria of the telephone tracking system. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated

in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2010, shall be invalid and void.

208.918. 1. In order to qualify for an agreement with the department, the vendor shall have a philosophy that promotes the consumer's ability to live independently in the most integrated setting or the maximum community inclusion of persons with physical disabilities, and shall demonstrate the ability to provide, directly or through contract, the following services:

(1) Orientation of consumers concerning the responsibilities of being an employer, supervision of personal care attendants including the preparation and verification of time sheets;

(2) Training for consumers about the recruitment and training of personal care attendants;

(3) Maintenance of a list of persons eligible to be a personal care attendant;

(4) Processing of inquiries and problems received from consumers and personal care attendants;

(5) Ensuring the personal care attendants are registered with the family care safety registry as provided in sections 210.900 to 210.937, RSMo; and

(6) The capacity to provide fiscal conduit services **through a telephone tracking system by the date required under section 208.909**.

2. In order to maintain its agreement with the department, a vendor shall comply with the provisions of subsection 1 of this section and shall:

(1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial reports and annual audit submitted to the department; and

(2) Demonstrate a positive impact on consumer outcomes regarding the provision of personal care assistance services as evidenced on accurate quarterly and annual service reports submitted to the department;

(3) Implement a quality assurance and supervision process that ensures program compliance and accuracy of records; and

(4) Comply with all provisions of sections 208.900 to 208.927, and the regulations promulgated thereunder.

660.023. 1. All in-home services provider agencies shall, by July 1, 2012, have, maintain, and use a telephone tracking system for the purpose of reporting and verifying the delivery of home and community-based services as authorized by the department of

health and senior services or its designee. Use of such system prior to July 1, 2012, shall be voluntary. At a minimum, the telephone tracking system shall:

(1) Record the exact date services are delivered;

(2) Record the exact time the services begin and exact time the services end;

(3) Verify the telephone number from which the services were registered;

(4) Verify that the number from which the call is placed is a telephone number unique to the client;

(5) Require a personal identification number unique to each personal care attendant; and

(6) Be capable of producing reports of services delivered, tasks performed, client identity, beginning and ending times of service and date of service in summary fashion that constitute adequate documentation of service.

2. The telephone tracking system shall be used to process payroll for employees and for submitting claims for reimbursement to the MO HealthNet division.

3. The department of health and senior services shall promulgate by rule the minimum necessary criteria of the telephone tracking system. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2010, shall be invalid and void.

4. As new technology becomes available, the department may allow use of a more advanced tracking system, provided that such system is at least as capable of meeting the requirements listed in subsection 1 of this section.

660.300. 1. When any adult day care worker; chiropractor; Christian Science practitioner; coroner; dentist; embalmer; employee of the departments of social services, mental health, or health and senior services; employee of a local area agency on aging or an organized area agency on aging program; funeral director; home health agency or home health agency employee; hospital and clinic personnel engaged in examination, care, or treatment of persons; in-home services owner, provider, operator, or employee; law enforcement officer; long-term care facility administrator or employee; medical examiner; medical resident or intern; mental health professional; minister; nurse; nurse practitioner; optometrist; other health practitioner; peace officer; pharmacist; physical therapist; physician; physician's assistant; podiatrist;

probation or parole officer; psychologist; or social worker has reasonable cause to believe that an in-home services client has been abused or neglected, as a result of in-home services, he or she shall immediately report or cause a report to be made to the department. If the report is made by a physician of the in-home services client, the department shall maintain contact with the physician regarding the progress of the investigation.

2. When a report of deteriorating physical condition resulting in possible abuse or neglect of an in-home services client is received by the department, the client's case manager and the department nurse shall be notified. The client's case manager shall investigate and immediately report the results of the investigation to the department nurse. The department may authorize the in-home services provider nurse to assist the case manager with the investigation.

3. If requested, local area agencies on aging shall provide volunteer training to those persons listed in subsection 1 of this section regarding the detection and report of abuse and neglect pursuant to this section.

4. Any person required in subsection 1 of this section to report or cause a report to be made to the department who fails to do so within a reasonable time after the act of abuse or neglect is guilty of a class A misdemeanor.

5. The report shall contain the names and addresses of the in-home services provider agency, the in-home services employee, the in-home services client, the home health agency, the home health agency employee, information regarding the nature of the abuse or neglect, the name of the complainant, and any other information which might be helpful in an investigation.

6. In addition to those persons required to report under subsection 1 of this section, any other person having reasonable cause to believe that an in-home services client or home health patient has been abused or neglected by an in-home services employee or home health agency employee may report such information to the department.

7. If the investigation indicates possible abuse or neglect of an in-home services client or home health patient, the investigator shall refer the complaint together with his or her report to the department director or his or her designee for appropriate action. If, during the investigation or at its completion, the department has reasonable cause to believe that immediate action is necessary to protect the in-home services client or home health patient from abuse or neglect, the department or the local prosecuting attorney may, or the attorney general upon request of the department shall, file a petition for temporary care and protection of the in-home services client or home health patient in a circuit court of competent jurisdiction. The circuit court in which the petition is filed shall have equitable jurisdiction to issue an ex parte order granting the department authority for the temporary care and protection of the in-home services client or home health patient, for a period not to exceed thirty days.

8. Reports shall be confidential, as provided under section 660.320.

9. Anyone, except any person who has abused or neglected an in-home services client or home health patient, who makes a report pursuant to this section or who testifies in any administrative or judicial proceeding arising from the report shall be immune from any civil or criminal liability for making such a report or for testifying except for liability for perjury, unless such person acted negligently, recklessly, in bad faith, or with malicious purpose.

10. Within five working days after a report required to be made under this section is received, the person making the report shall be notified in writing of its receipt and of the initiation of the investigation.

11. No person who directs or exercises any authority in an in-home services provider agency or home health agency shall harass, dismiss or retaliate against an in-home services client or home health patient, or an in-home services employee or a home health agency employee because he or any member of his or her family has made a report of any violation or suspected violation of laws, standards or regulations applying to the in-home services provider agency or home health agency or any in-home services employee or home health agency employee which he has reasonable cause to believe has been committed or has occurred.

12. Any person who abuses or neglects an in-home services client or home health patient is subject to criminal prosecution under section 565.180, 565.182, or 565.184, RSMo. If such person is an in-home services employee and has been found guilty by a court, and if the supervising in-home services provider willfully and knowingly failed to report known abuse by such employee to the department, the supervising in-home services provider may be subject to administrative penalties of one thousand dollars per violation to be collected by the department and the money received therefor shall be paid to the director of revenue and deposited in the state treasury to the credit of the general revenue fund. Any in-home services provider which has had administrative penalties imposed by the department or which has had its contract terminated may seek an administrative review of the department's action pursuant to chapter 621, RSMo. Any decision of the administrative hearing commission may be appealed to the circuit court in the county where the violation occurred for a trial de novo. For purposes of this subsection, the term "violation" means a determination of guilt by a court.

13. The department shall establish a quality assurance and supervision process for clients that requires an in-home services provider agency to conduct random visits to verify compliance with program standards and verify the accuracy of records kept by an in-home services employee.

14. The department shall maintain the employee disqualification list and place on the employee disqualification list the names of any persons who have been finally determined by the department, pursuant to section 660.315, to have recklessly, knowingly or purposely abused or

neglected an in-home services client or home health patient while employed by an in-home services provider agency or home health agency. For purposes of this section only, "knowingly" and "recklessly" shall have the meanings that are ascribed to them in this section. A person acts "knowingly" with respect to the person's conduct when a reasonable person should be aware of the result caused by his or her conduct. A person acts "recklessly" when the person consciously disregards a substantial and unjustifiable risk that the person's conduct will result in serious physical injury and such disregard constitutes a gross deviation from the standard of care that a reasonable person would exercise in the situation.

15. At the time a client has been assessed to determine the level of care as required by rule and is eligible for in-home services, the department shall conduct a "Safe at Home Evaluation" to determine the client's physical, mental, and environmental capacity. The department shall develop the safe at home evaluation tool by rule in accordance with chapter 536, RSMo. The purpose of the safe at home evaluation is to assure that each client has the appropriate level of services and professionals involved in the client's care. The plan of service or care for each in-home services client shall be authorized by a nurse. The department may authorize the licensed in-home services nurse, in lieu of the department nurse, to conduct the assessment of the client's condition and to establish a plan of services or care. The department may use the expertise, services, or programs of other departments and agencies on a case-by-case basis to establish the plan of service or care.

The department may, as indicated by the safe at home evaluation, refer any client to a mental health professional, as defined in 9 CSR 30-4.030, for evaluation and treatment as necessary.

16. Authorized nurse visits shall occur at least twice annually to assess the client and the client's plan of services. The provider nurse shall report the results of his or her visits to the client's case manager. If the provider nurse believes that the plan of service requires alteration, the department shall be notified and the department shall make a client evaluation. All authorized nurse visits shall be reimbursed to the in-home services provider. All authorized nurse visits shall be reimbursed outside of the nursing home cap for in-home services clients whose services have reached one hundred percent of the average statewide charge for care and treatment in an intermediate care facility, provided that the services have been preauthorized by the department.

17. All in-home services clients shall be advised of their rights by the department **or the department's designee** at the initial evaluation. The rights shall include, but not be limited to, the right to call the department for any reason, including dissatisfaction with the provider or services. **The department may contract for services relating to receiving such complaints.**

The department shall establish a process to receive such nonabuse and neglect calls other than the elder abuse and neglect hotline.

18. Subject to appropriations, all nurse visits authorized in sections 660.250 to 660.300 shall be reimbursed to the in-home services provider agency.

Section 1. Any state elected official who tests positive for drugs as defined by section 105.012 , shall be subject to any sanction authorized by law or rule of the respective official.

Section 2. The department of social services shall develop policies and procedures by January 1, 2011, that make it possible for the state to qualify for unrestricted federal bonus funds appropriated in the federal Children's Health Insurance Program Reauthorization Act.

Section B. Because immediate action is necessary to preserve state services, the repeal and renactment of sections 148.340, 148.350, 148.370, and 148.380, of Section A of this act are deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the repeal and renactment of sections 148.340, 148.350, 148.370, and 148.380 of Section A of this act shall be in full force and effect upon its passage and approval.

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