

SECOND REGULAR SESSION

HOUSE BILL NO. 1918

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE SATER.

4872L.011

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 208.010, 208.152, 208.166, 208.227, 208.895, 208.903, 208.909, 208.918, and 660.300, RSMo, and to enact in lieu thereof nine new sections relating to public assistance programs administered by the state, with a penalty provision.

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

Section A. Sections 208.010, 208.152, 208.166, 208.227, 208.895, 208.903, 208.909, 208.918, and 660.300, RSMo, are repealed and nine new sections enacted in lieu thereof, to be known as sections 208.010, 208.152, 208.166, 208.227, 208.903, 208.909, 208.918, 660.300, and 1, to read as follows:

208.010. 1. In determining the eligibility of a claimant for public assistance pursuant to this law, it shall be the duty of the division of family services to consider and take into account all facts and circumstances surrounding the claimant, including his or her living conditions, earning capacity, income and resources, from whatever source received, and if from all the facts and circumstances the claimant is not found to be in need, assistance shall be denied. In determining the need of a claimant, the costs of providing medical treatment which may be furnished pursuant to sections 208.151 to 208.158 and 208.162 shall be disregarded. The amount of benefits, when added to all other income, resources, support, and maintenance shall provide such persons with reasonable subsistence compatible with decency and health in accordance with the standards developed by the division of family services; provided, when a husband and wife are living together, the combined income and resources of both shall be considered in determining the eligibility of either or both. "Living together" for the purpose of this chapter is defined as including a husband and wife separated for the purpose of obtaining medical care or nursing home care, except that the income of a husband or wife separated for such purpose shall

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.

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

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

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

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

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

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

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

48 (2) The provisions of subdivision (1) of this subsection shall not apply to a transfer, other
49 than a transfer to claimant's spouse, made prior to March 26, 1981, when the claimant furnishes

50 convincing evidence that the uncompensated value of the disposed of resource or any part thereof
51 is no longer possessed or owned by the person to whom the resource was transferred;

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

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

64 (5) Prior to October 1, 1989, owns or possesses property of any kind or character,
65 excluding amounts placed in an irrevocable prearranged funeral or burial contract pursuant to
66 subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053,
67 RSMo, or has an interest in property, of which he or she is the record or beneficial owner, the
68 value of such property, as determined by the division of family services, less encumbrances of
69 record, exceeds twenty-nine thousand dollars, or if married and actually living together with
70 husband or wife, if the value of his or her property, or the value of his or her interest in property,
71 together with that of such husband and wife, exceeds such amount;

72 (6) In the case of temporary assistance for needy families, if the parent, stepparent, and
73 child or children in the home owns or possesses property of any kind or character, or has an
74 interest in property for which he or she is a record or beneficial owner, the value of such
75 property, as determined by the division of family services and as allowed by federal law or
76 regulation, less encumbrances of record, exceeds one thousand dollars, excluding the home
77 occupied by the claimant, amounts placed in an irrevocable prearranged funeral or burial contract
78 pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of
79 section 436.053, RSMo, one automobile which shall not exceed a value set forth by federal law
80 or regulation and for a period not to exceed six months, such other real property which the family
81 is making a good-faith effort to sell, if the family agrees in writing with the division of family
82 services to sell such property and from the net proceeds of the sale repay the amount of
83 assistance received during such period. If the property has not been sold within six months, or
84 if eligibility terminates for any other reason, the entire amount of assistance paid during such
85 period shall be a debt due the state;

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

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

91 4. In determining eligibility and the amount of benefits to be granted pursuant to
92 federally aided programs, the value of burial lots or any amounts placed in an irrevocable
93 prearranged funeral or burial contract pursuant to subsection 2 of section 436.035, RSMo, and
94 subdivision (5) of subsection 1 of section 436.053, RSMo, shall not be taken into account or
95 considered an asset of the burial lot owner or the beneficiary of an irrevocable prearranged
96 funeral or funeral contract. For purposes of this section, "burial lots" means any burial space as
97 defined in section 214.270, RSMo, and any memorial, monument, marker, tombstone or letter
98 marking a burial space. If the beneficiary, as defined in chapter 436, RSMo, of an irrevocable
99 prearranged funeral or burial contract receives any public assistance benefits pursuant to this
100 chapter and if the purchaser of such contract or his or her successors in interest cancel or amend
101 the contract so that any person will be entitled to a refund, such refund shall be paid to the state
102 of Missouri up to the amount of public assistance benefits provided pursuant to this chapter with
103 any remainder to be paid to those persons designated in chapter 436, RSMo.

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

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

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

117 6. Beginning September 30, 1989, when determining the eligibility of institutionalized
118 spouses, as defined in 42 U.S.C. Section 1396r-5, for medical assistance benefits as provided for
119 in section 208.151 and 42 U.S.C. Sections 1396a et seq., the division of family services shall
120 comply with the provisions of the federal statutes and regulations. As necessary, the division
121 shall by rule or regulation implement the federal law and regulations which shall include but not

122 be limited to the establishment of income and resource standards and limitations. The division
123 shall require:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (3) Laboratory and X-ray services;

22 (4) Nursing home services for participants, except to persons with more than five
23 hundred thousand dollars equity in their home or except for persons in an institution for mental

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

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

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

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

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

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

55 (10) Home health care services;

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

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

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

69 (14) Personal care services which are medically oriented tasks having to do with a
70 person's physical requirements, as opposed to housekeeping requirements, which enable a person
71 to be treated by his physician on an outpatient rather than on an inpatient or residential basis in
72 a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be
73 rendered by an individual not a member of the participant's family who is qualified to provide
74 such services where the services are prescribed by a physician in accordance with a plan of
75 treatment and are supervised by a licensed nurse. Persons eligible to receive personal care
76 services shall be those persons who would otherwise require placement in a hospital,
77 intermediate care facility, or skilled nursing facility. Benefits payable for personal care services
78 shall not exceed for any one participant [one hundred percent of the average statewide charge for
79 care and treatment in an intermediate care facility for a comparable period of time] **three and**
80 **one-half hours per day and sixty hours per calendar month. Where the need for personal**
81 **care services has been demonstrated to exceed sixty hours per calendar month, the state**
82 **may authorize up to twenty additional hours per calendar month of personal care services.**
83 Such services, when delivered in a residential care facility or assisted living facility licensed
84 under chapter 198, RSMo, shall be authorized on a tier level based on the services the resident
85 requires and the frequency of the services. A resident of such facility who qualifies for
86 assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for
87 the tier level with the fewest services. The rate paid to providers for each tier of service shall be
88 set subject to appropriations. Subject to appropriations, each resident of such facility who
89 qualifies for assistance under section 208.030 and meets the level of care required in this section
90 shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care
91 services per day. Authorized units of personal care services shall not be reduced or tier level
92 lowered unless an order approving such reduction or lowering is obtained from the resident's
93 personal physician. Such authorized units of personal care services or tier level shall be
94 transferred with such resident if her or she transfers to another such facility. Such provision shall
95 terminate upon receipt of relevant waivers from the federal Department of Health and Human

96 Services. If the Centers for Medicare and Medicaid Services determines that such provision does
97 not comply with the state plan, this provision shall be null and void. The MO HealthNet division
98 shall notify the revisor of statutes as to whether the relevant waivers are approved or a
99 determination of noncompliance is made;

100 (15) Mental health services. The state plan for providing medical assistance under Title
101 XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental
102 health services when such services are provided by community mental health facilities operated
103 by the department of mental health or designated by the department of mental health as a
104 community mental health facility or as an alcohol and drug abuse facility or as a child-serving
105 agency within the comprehensive children's mental health service system established in section
106 630.097, RSMo. The department of mental health shall establish by administrative rule the
107 definition and criteria for designation as a community mental health facility and for designation
108 as an alcohol and drug abuse facility. Such mental health services shall include:

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

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

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

132 addition, the agreement shall establish a mechanism by which rates for services may be jointly
133 developed;

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

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

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

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

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

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

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

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

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

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

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

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

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

188 (23) The MO HealthNet division shall, by January 1, 2008, and annually thereafter,
189 report the status of MO HealthNet provider reimbursement rates as compared to one hundred
190 percent of the Medicare reimbursement rates and compared to the average dental reimbursement
191 rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July
192 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare
193 reimbursement rates and for third-party payor average dental reimbursement rates. Such plan
194 shall be subject to appropriation and the division shall include in its annual budget request to the
195 governor the necessary funding needed to complete the four-year plan developed under this
196 subdivision.

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

202 (1) Dental services;

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

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

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

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

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

235 3. The MO HealthNet division may require any participant receiving MO HealthNet
236 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July
237 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered
238 services except for those services covered under subdivisions (14) and (15) of subsection 1 of

239 this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title
240 XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder.
241 When substitution of a generic drug is permitted by the prescriber according to section 338.056,
242 RSMo, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may
243 not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX
244 of the federal Social Security Act. A provider of goods or services described under this section
245 must collect from all participants the additional payment that may be required by the MO
246 HealthNet division under authority granted herein, if the division exercises that authority, to
247 remain eligible as a provider. Any payments made by participants under this section shall be in
248 addition to and not in lieu of payments made by the state for goods or services described herein
249 except the participant portion of the pharmacy professional dispensing fee shall be in addition
250 to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time
251 a service is provided or at a later date. A provider shall not refuse to provide a service if a
252 participant is unable to pay a required payment. If it is the routine business practice of a provider
253 to terminate future services to an individual with an unclaimed debt, the provider may include
254 uncollected co-payments under this practice. Providers who elect not to undertake the provision
255 of services based on a history of bad debt shall give participants advance notice and a reasonable
256 opportunity for payment. A provider, representative, employee, independent contractor, or agent
257 of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection
258 shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for
259 Medicare and Medicaid Services does not approve the Missouri MO HealthNet state plan
260 amendment submitted by the department of social services that would allow a provider to deny
261 future services to an individual with uncollected co-payments, the denial of services shall not be
262 allowed. The department of social services shall inform providers regarding the acceptability
263 of denying services as the result of unpaid co-payments.

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

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

272 6. Beginning July 1, 1990, reimbursement for services rendered in federally funded
273 health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404

274 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations
275 promulgated thereunder.

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

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

285 9. Reimbursement rates to long-term care providers with respect to a total change in
286 ownership, at arm's length, for any facility previously licensed and certified for participation in
287 the MO HealthNet program shall not increase payments in excess of the increase that would
288 result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C.
289 1396a (a)(13)(C).

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

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

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

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

3 (2) "Prepaid capitated", a mode of payment by which the department periodically
4 reimburse a contracted health provider plan or primary care physician sponsor for delivering
5 health care services for the duration of a contract to a maximum specified number of members
6 based on a fixed rate per member, notwithstanding:

7 (a) The actual number of members who receive care from the provider; or

8 (b) The amount of health care services provided to any members;

9 (3) "Primary care case-management", a mode of payment by which the department
10 reimburses a contracted primary care physician sponsor on a fee-for-service schedule plus a
11 monthly fee to manage each recipient's case;

12 (4) "Primary care physician sponsor", a physician licensed pursuant to chapter 334,
13 RSMo, who is a family practitioner, general practitioner, pediatrician, general internist or an
14 obstetrician or gynecologist;

15 (5) "Specialty physician services arrangement", an arrangement where the department
16 may restrict recipients of specialty services to designated providers of such services, even in the
17 absence of a primary care case-management system.

18 2. The department or its designated division shall maximize the use of prepaid health
19 plans, where appropriate, and other alternative service delivery and reimbursement
20 methodologies, including, but not limited to, individual primary care physician sponsors or
21 specialty physician services arrangements, designed to facilitate the cost-effective purchase of
22 comprehensive health care.

23 3. In order to provide comprehensive health care, the department or its designated
24 division shall have authority to:

25 (1) Purchase medical services for recipients of public assistance from prepaid health
26 plans, health maintenance organizations, health insuring organizations, preferred provider
27 organizations, individual practice associations, local health units, community health centers, or
28 primary care physician sponsors;

29 (2) Reimburse those health care plans or primary care physicians' sponsors who enter
30 into direct contract with the department on a prepaid capitated or primary care case-management
31 basis on the following conditions:

32 (a) That the department or its designated division shall ensure, whenever possible and
33 consistent with quality of care and cost factors, that publicly supported neighborhood and
34 community-supported health clinics shall be utilized as providers;

35 (b) That the department or its designated division shall ensure reasonable access to
36 medical services in geographic areas where managed or coordinated care programs are initiated;
37 and

38 (c) That the department shall ensure full freedom of choice for prescription drugs at any
39 Medicaid participating pharmacy;

40 (3) Limit providers of medical assistance benefits to those who demonstrate efficient and
41 economic service delivery for the level of service they deliver, and provided that such limitation
42 shall not limit recipients from reasonable access to such levels of service;

43 (4) Provide recipients of public assistance with alternative services as provided for in
44 state law, subject to appropriation by the general assembly;

45 (5) Designate providers of medical assistance benefits to assure specifically defined
46 medical assistance benefits at a reduced cost to the state, to assure reasonable access to all levels
47 of health services and to assure maximization of federal financial participation in the delivery
48 of health related services to Missouri citizens; provided, all qualified providers that deliver such
49 specifically defined services shall be afforded an opportunity to compete to meet reasonable state
50 criteria and to be so designated;

51 (6) Upon mutual agreement with any entity of local government, to elect to use local
52 government funds as the matching share for Title XIX payments, as allowed by federal law or
53 regulation;

54 (7) To elect not to offset local government contributions from the allowable costs under
55 the Title XIX program, unless prohibited by federal law and regulation;

56 **(8) Require that a prepaid health plan may limit any reimbursement it may be**
57 **required to pay to providers not employed by or under contract with the prepaid health**
58 **plan up to ninety-five percent of the medical assistance rates for medical assistance**
59 **enrollees paid by the MO HealthNet division to enrolled providers for services to MO**
60 **HealthNet participants not enrolled in a prepaid health plan.**

61 4. Nothing in this section shall be construed to authorize the department or its designated
62 division to limit the recipient's freedom of selection among health care plans or primary care
63 physician sponsors, as authorized in this section, who have entered into contract with the
64 department or its designated division to provide a comprehensive range of health care services
65 on a prepaid capitated or primary care case-management basis, except in those instances of
66 overutilization of Medicaid services by the recipient.

208.227. 1. Fee for service eligible policies for prescribing psychotropic medications
2 shall not include any new limits to initial access requirements, except dose optimization or new
3 drug combinations consisting of one or more existing drug entities or preference algorithms for
4 SSRI antidepressants, **except as otherwise provided in subsections 2 and 3 of this section**, for
5 persons with mental illness diagnosis, or other illnesses for which treatment with psychotropic
6 medications are indicated and the drug has been approved by the federal Food and Drug
7 Administration for at least one indication and is a recognized treatment in one of the standard
8 reference compendia or in substantially accepted peer-reviewed medical literature and deemed
9 medically appropriate for a diagnosis. No restrictions to access shall be imposed that preclude
10 availability of any individual atypical antipsychotic monotherapy for the treatment of
11 schizophrenia, bipolar disorder, or psychosis associated with severe depression, **except as**
12 **otherwise provided in subsections 2 and 3 of this section.**

13 **2. (1) The MO HealthNet division within the department of social services shall by**
14 **rule establish the "Psychotropic Medication Review Subcommittee of the MO HealthNet**
15 **Drug Prior Authorization Committee" for the review of psychotropic medications. The**
16 **subcommittee shall develop, access, use, and monitor requirements for all medications**
17 **approved by the United States Food and Drug Administration (FDA) as agents which may**
18 **be prescribed in the treatment of behavioral health issues. All members shall be appointed**
19 **by the director of the department of social services, in consultation with the director of the**
20 **department of mental health. Members shall serve for a term of four years or until their**

21 successor is qualified. Members of the committee shall receive no compensation for their
22 services, but shall be reimbursed for their actual and necessary expenses incurred, as
23 approved by the MO HealthNet division, out of appropriations made for such purpose.

24 (2) The subcommittee shall meet no less than twice a year and shall be comprised
25 of eight members consisting of at least the following:

26 (a) One psychiatrist licensed under chapter 334;

27 (b) One pediatrician or child psychiatrist licensed under chapter 334;

28 (c) One clinically trained representative of the department of mental health;

29 (d) Two pharmacists licensed under chapter 338 and who hold a doctor of
30 pharmacy degree; and

31 (e) Three public members who participate in mental health advocacy. The public
32 members shall be chosen from a slate of recommendations made by recognized mental
33 health advocacy organizations. The organizations shall be identified by the Missouri
34 mental health commission as those organizations with sufficient membership as to be
35 representative of the mental health community.

36 3. The department shall promulgate rules to implement the provisions of this
37 section. Any rule or portion of a rule, as that term is defined in section 536.010, that is
38 created under the authority delegated in this section shall become effective only if it
39 complies with and is subject to all of the provisions of chapter 536 and, if applicable,
40 section 536.028. This section and chapter 536 are nonseverable and if any of the powers
41 vested with the general assembly pursuant to chapter 536 to review, to delay the effective
42 date, or to disapprove and annul a rule are subsequently held unconstitutional, then the
43 grant of rulemaking authority and any rule proposed or adopted after August 28, 2010,
44 shall be invalid and void.

208.903. 1. Subject to appropriations, the department shall provide financial assistance
2 for consumer-directed personal care assistance services through eligible vendors to each person
3 determined eligible to participate under guidelines established by the Medicaid state plan and
4 who:

5 (1) Is capable of living independently with personal care assistance services;

6 (2) Is physically disabled;

7 (3) Is eighteen years of age or older;

8 (4) Is able to direct his or her own care;

9 (5) Is able to document proof of Medicaid eligibility under Title XIX of the Social
10 Security Act under federal and state laws and regulations;

11 (6) Requires at least a nursing home level of care under regulations established by the
12 department;

13 (7) Participates in an assessment or evaluation, or both, by the department; and

14 (8) Can have their unmet needs safely met [at a cost that shall not exceed the average
15 monthly Medicaid cost of nursing facility care as determined by the department of social
16 services] **through an authorization not to exceed three and one-half hours per day and sixty
17 hours per calendar month of personal care services. Where the need for personal care
18 services has been demonstrated to exceed sixty hours per calendar month, the state may
19 authorize up to twenty additional hours per calendar month of personal care services.**

20 2. Upon certification of the employment of a personal care attendant chosen by the
21 consumer in accordance with sections 208.900 to 208.927, the vendor shall perform the payroll
22 and fringe benefit accounting functions for the consumer. The vendor shall be responsible for
23 filing claims with the Missouri Medicaid program. Statutorily required fringe benefit costs shall
24 be paid from the personal care assistant appropriation. The department shall establish the
25 statewide rate for personal care attendant services. For purposes of this section, the personal care
26 attendant is considered the employee of the consumer only for the period of time subsidized by
27 personal care assistant funds. Nothing in this section shall be construed to mean that the
28 attendant is the employee of the vendor, the department, or the state of Missouri.

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

3 (1) Supervising their personal care attendant;

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

5 (3) [Preparing and submitting time sheets, signed by both the consumer and personal
6 care attendant, to the vendor on a biweekly basis] **Approving reimbursement requests using
7 a system that assures accuracy and compliance with program exceptions for both the
8 consumer and vendor;**

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

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

15 (6) **Provide the vendor with all necessary information to complete required
16 paperwork for establishing the employer identification number.**

17 2. Participating vendors shall be responsible for:

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

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

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

24 (4)] **Maintaining and utilizing a telephone tracking system for the purpose of**
25 **reporting and verifying the delivery of consumer-directed services as authorized by the**
26 **department of health and senior services or the department's designee. The department**
27 **shall by rule promulgate the minimum necessary criteria of the telephone tracking system.**
28 **The system shall be utilized to process payroll for employees and submitting claims for**
29 **reimbursement to the MO HealthNet division. Vendors with more than one hundred fifty**
30 **consumers shall have a fully operational telephone tracking system by July 1, 2011.**
31 **Vendors with one hundred fifty or fewer consumers shall have a fully operation telephone**
32 **tracking system by July 1, 2012. At a minimum, the system shall:**

33 (a) **Record the exact date services are delivered;**

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

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

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

38 (e) **Require a personal identification number unique to each personal care**
39 **attendant;**

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

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

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

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

55 **5. Any rule or portion of a rule, as that term is defined in section 536.010, that is**
56 **created under the authority delegated in this section shall become effective only if it**
57 **complies with and is subject to all of the provisions of chapter 536 and, if applicable,**
58 **section 536.028. This section and chapter 536 are nonseverable and if any of the powers**
59 **vested with the general assembly pursuant to chapter 536 to review, to delay the effective**
60 **date, or to disapprove and annul a rule are subsequently held unconstitutional, then the**
61 **grant of rulemaking authority and any rule proposed or adopted after August 28, 2010,**
62 **shall be invalid and void.**

 208.918. 1. In order to qualify for an agreement with the department, the vendor shall
2 have a philosophy that promotes the consumer's ability to live independently in the most
3 integrated setting or the maximum community inclusion of persons with physical disabilities,
4 and shall demonstrate the ability to provide, directly or through contract, the following services:
5 (1) Orientation of consumers concerning the responsibilities of being an employer,
6 supervision of personal care attendants including the preparation and verification of time sheets;
7 (2) Training for consumers about the recruitment and training of personal care
8 attendants;
9 (3) Maintenance of a list of persons eligible to be a personal care attendant;
10 (4) Processing of inquiries and problems received from consumers and personal care
11 attendants;
12 (5) Ensuring the personal care attendants are registered with the family care safety
13 registry as provided in sections 210.900 to 210.937, RSMo; and
14 (6) The capacity to provide fiscal conduit services **through a telephone tracking**
15 **system by the date required in section 208.909.**

16 2. In order to maintain its agreement with the department, a vendor shall comply with
17 the provisions of subsection 1 of this section and shall:
18 (1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial
19 reports and annual audit submitted to the department; and
20 (2) Demonstrate a positive impact on consumer outcomes regarding the provision of
21 personal care assistance services as evidenced on accurate quarterly and annual service reports
22 submitted to the department;
23 (3) Implement a quality assurance and supervision process that ensures program
24 compliance and accuracy of records; and
25 (4) Comply with all provisions of sections 208.900 to 208.927, and the regulations
26 promulgated thereunder.

 660.300. 1. When any adult day care worker; chiropractor; Christian Science
2 practitioner; coroner; dentist; embalmer; employee of the departments of social services, mental

3 health, or health and senior services; employee of a local area agency on aging or an organized
4 area agency on aging program; funeral director; home health agency or home health agency
5 employee; hospital and clinic personnel engaged in examination, care, or treatment of persons;
6 in-home services owner, provider, operator, or employee; law enforcement officer; long-term
7 care facility administrator or employee; medical examiner; medical resident or intern; mental
8 health professional; minister; nurse; nurse practitioner; optometrist; other health practitioner;
9 peace officer; pharmacist; physical therapist; physician; physician's assistant; podiatrist;
10 probation or parole officer; psychologist; or social worker has reasonable cause to believe that
11 an in-home services client has been abused or neglected, as a result of in-home services, he or
12 she shall immediately report or cause a report to be made to the department. If the report is made
13 by a physician of the in-home services client, the department shall maintain contact with the
14 physician regarding the progress of the investigation.

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

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

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

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

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

34 7. If the investigation indicates possible abuse or neglect of an in-home services client
35 or home health patient, the investigator shall refer the complaint together with his or her report
36 to the department director or his or her designee for appropriate action. If, during the
37 investigation or at its completion, the department has reasonable cause to believe that immediate
38 action is necessary to protect the in-home services client or home health patient from abuse or

39 neglect, the department or the local prosecuting attorney may, or the attorney general upon
40 request of the department shall, file a petition for temporary care and protection of the in-home
41 services client or home health patient in a circuit court of competent jurisdiction. The circuit
42 court in which the petition is filed shall have equitable jurisdiction to issue an ex parte order
43 granting the department authority for the temporary care and protection of the in-home services
44 client or home health patient, for a period not to exceed thirty days.

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

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

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

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

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

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

77 14. The department shall maintain the employee disqualification list and place on the
78 employee disqualification list the names of any persons who have been finally determined by the
79 department, pursuant to section 660.315, to have recklessly, knowingly or purposely abused or
80 neglected an in-home services client or home health patient while employed by an in-home
81 services provider agency or home health agency. For purposes of this section only, "knowingly"
82 and "recklessly" shall have the meanings that are ascribed to them in this section. A person acts
83 "knowingly" with respect to the person's conduct when a reasonable person should be aware of
84 the result caused by his or her conduct. A person acts "recklessly" when the person consciously
85 disregards a substantial and unjustifiable risk that the person's conduct will result in serious
86 physical injury and such disregard constitutes a gross deviation from the standard of care that a
87 reasonable person would exercise in the situation.

88 15. At the time a client has been assessed to determine the level of care as required by
89 rule and is eligible for in-home services, the department shall conduct a "Safe at Home
90 Evaluation" to determine the client's physical, mental, and environmental capacity. The
91 department shall develop the safe at home evaluation tool by rule in accordance with chapter
92 536, RSMo. The purpose of the safe at home evaluation is to assure that each client has the
93 appropriate level of services and professionals involved in the client's care.
94 The plan of service or care for each in-home services client shall be authorized by a nurse. The
95 department may authorize the licensed in-home services nurse, in lieu of the department nurse,
96 to conduct the assessment of the client's condition and to establish a plan of services or care. The
97 department may use the expertise, services, or programs of other departments and agencies on
98 a case-by-case basis to establish the plan of service or care.
99 The department may, as indicated by the safe at home evaluation, refer any client to a mental
100 health professional, as defined in 9 CSR 30-4.030, for evaluation and treatment as necessary.

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

110 17. All in-home services clients shall be advised of their rights by the department **or**
111 **their designee** at the initial evaluation. The rights shall include, but not be limited to, the right
112 to call the department for any reason, including dissatisfaction with the provider or services. **The**
113 **department may contract for such services.** The department shall establish a process to
114 receive such nonabuse and neglect calls other than the elder abuse and neglect hotline.

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

Section 1. 1. All in-home services provider agencies shall have, maintain, and
2 **utilize a telephone tracking system for the purpose of reporting and verifying the delivery**
3 **of consumer-directed services as authorized by the department of health and senior**
4 **services or the department's designee. At a minimum, the system shall:**

5 (1) **Record the exact date services are delivered;**

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

7 (3) **Verify the telephone number from which the services are registered;**

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

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

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

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

17 3. **Providers with more than one hundred fifty consumers shall have a fully**
18 **operational telephone tracking system by July 1, 2011. Providers with one hundred fifty**
19 **or fewer consumers shall have a fully operational telephone tracking system by July 1,**
20 **2012.**

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

2 [208.895. Upon receipt of a properly completed referral for MO
3 HealthNet-funded home- and community-based care containing a nurse
4 assessment or physician's order, the department of health and senior services
5 shall:

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

8 (2) Issue a prior-authorization for home and community-based services
9 when information contained in the referral is sufficient to establish eligibility for
10 MO HealthNet-funded long-term care and determine the level of service need as
11 required under state and federal regulations;

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

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

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

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

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

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