SECOND REGULAR SESSION

SENATE BILL NO. 739

97TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR ROMINE.

Read 1st time January 16, 2014, and ordered printed.

TERRY L. SPIELER, Secretary.

5381S.03I

AN ACT

To repeal sections 208.010, 208.151, 208.631, 208.670, 208.950, 208.952, 208.990, and 208.991, RSMo, and to enact in lieu thereof seventeen new sections relating to the MO HealthNet program.

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

Section A. Sections 208.010, 208.151, 208.631, 208.670, 208.950, 208.952, 208.990, and 208.991, RSMo, are repealed and seventeen new sections enacted in lieu thereof, to be known as sections 208.010, 208.151, 208.186, 208.631, 208.661, 208.662, 208.670, 208.950, 208.952, 208.990, 208.991, 208.997, 208.998, 208.999, 208.1500, 208.1503, and 208.1506, to read as follows:

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

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

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

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

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

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

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

a. When the uncompensated value is twelve thousand dollars or less, the

resource shall not be used in determining eligibility for more than twenty-four months; or

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

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

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

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

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

(6) In the case of temporary assistance for needy families, if the parent, stepparent, and child or children in the home owns or possesses property of any kind or character, or has an interest in property for which he or she is a record or beneficial owner, the value of such property, as determined by the family

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

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

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

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

consideration for an irrevocable prearranged funeral contract under chapter 436, shall not be taken into account or considered an asset of the beneficiary of the irrevocable prearranged funeral contract. In addition, the value of any funds, up to nine thousand nine hundred ninety-nine dollars, placed into an irrevocable personal funeral trust account, where the trustee of the irrevocable personal funeral trust account is a state or federally chartered financial institution authorized to exercise trust powers in the state of Missouri, shall not be taken into account or considered an asset of the person whose funds are so deposited if such funds are restricted to be used only for the burial, funeral, preparation of the body, or other final disposition of the person whose funds were deposited into said personal funeral trust account. No person or entity shall charge more than ten percent of the total amount deposited into a personal funeral trust in order to create or set up said personal funeral trust, and any fees charged for the maintenance of such a personal funeral trust shall not exceed three percent of the trust assets annually. Trustees may commingle funds from two or more such personal funeral trust accounts so long as accurate books and records are kept as to the value, deposits, and disbursements of each individual depositor's funds and trustees are to use the prudent investor standard as to the investment of any funds placed into a personal funeral trust. If the person whose funds are deposited into the personal funeral trust account receives any public assistance benefits pursuant to this chapter and any funds in the personal funeral trust account are, for any reason, not spent on the burial, funeral, preparation of the body, or other final disposition of the person whose funds were deposited into the trust account, such funds shall be paid to the state of Missouri with any amount in excess of the public assistance benefits provided under this chapter to be refunded by the state of Missouri to the person who received public assistance benefits or his or her successors. No contract with any cemetery, funeral establishment, or any provider or seller shall be required in regards to funds placed into a personal funeral trust account as set out in this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

persons shall be eligible to receive MO HealthNet benefits to the extent and in the manner hereinafter provided**, unless otherwise provided in subsection 2 of this section**:

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

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

(3) All participants receiving blind pension benefits;

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

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

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

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

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

(9) All persons who were participants receiving old age assistance benefits, aid to the permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who continue to meet the eligibility requirements,

except income, for these assistance categories, but who are no longer receiving such benefits because of the implementation of Title XVI of the federal Social Security Act, as amended;

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

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

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

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

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of age, the family support division shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency. As necessary to provide MO HealthNet coverage under this subdivision, the department of social services may revise the state MO HealthNet plan to extend coverage under 42 U.S.C. 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42 U.S.C. 1396a;

(15) The family support division shall not establish a resource eligibility standard in assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The MO HealthNet division shall define the amount and scope

of benefits which are available to individuals eligible under each of the subdivisions (12), (13), and (14) of this subsection, in accordance with the requirements of federal law and regulations promulgated thereunder;

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

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

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

(19) Subject to appropriations necessary to recruit and train such staff, the family support division shall provide one or more full-time, permanent eligibility specialists to process applications for MO HealthNet benefits at the site of a health care provider, if the health care provider requests the placement of

such eligibility specialists and reimburses the division for the expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment of such eligibility specialists. The division may provide a health care provider with a part-time or temporary eligibility specialist at the site of a health care provider if the health care provider requests the placement of such an eligibility specialist and reimburses the division for the expenses, including but not limited to the salary, benefits, travel, training, telephone, supplies, and equipment, of such an eligibility specialist. The division may seek to employ such eligibility specialists who are otherwise qualified for such positions and who are current or former welfare participants. The division may consider training such current or former welfare participants as eligibility specialists for this program;

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

(21) Case management services for pregnant women and young children at risk shall be a covered service. To the greatest extent possible, and in compliance with federal law and regulations, the department of health and senior services shall provide case management services to pregnant women by contract or agreement with the department of social services through local health departments organized under the provisions of chapter 192 or chapter 205 or a city health department operated under a city charter or a combined city-county health department or other department of health and senior services designees. To the greatest extent possible the department of social services and the department of health and senior services shall mutually coordinate all services for pregnant women and children with the crippled children's program, the prevention of intellectual disability and developmental disability program and the prenatal care program administered by the department of health and senior services. The department of social services shall by regulation establish the methodology for reimbursement for case management services provided by the department of health and senior services. For purposes of this section, the term "case management" shall mean those activities of local public health personnel to identify prospective MO HealthNet-eligible high-risk mothers and enroll them in the state's MO HealthNet program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who

participate in the MO HealthNet program for prenatal care and to ensure that said high-risk mothers receive support from all private and public programs for which they are eligible and shall not include involvement in any MO HealthNet prepaid, case-managed programs;

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

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

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

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

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

(25) Persons who have been diagnosed with breast or cervical cancer and

who are eligible for coverage pursuant to 42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. 1396r-1;

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

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

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

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

2. **Beginning July 1, 2015, eligibility for MO HealthNet benefits shall be amended as follows:**

(1) Persons eligible under subdivision (25) of subsection 1 of this section shall no longer be eligible for MO HealthNet benefits as provided in this section, except for those persons who do not have access to employer-sponsored health insurance coverage or subsidized insurance coverage through an exchange at any point after diagnosis, whose income is between one hundred percent and two hundred percent of the federal poverty level as converted to the MAGI equivalent net income standard;

(2) Pregnant women who are eligible under subdivision (12) of subsection 1 of this section, with income between one hundred thirty-three and one hundred eighty-five percent of the federal poverty level as converted to the MAGI equivalent net income standard shall be eligible for MO HealthNet in the form of a premium subsidy as established by rule of the department in order for them to enroll in a plan offered by a health care exchange, whether federally facilitated, state based, or operated on a partnership basis. The pregnant women shall be directed to choose an exchange plan and shall be eligible for a premium subsidy equal to the amount of the percentage of income required for premium payments or coinsurance to the pregnant women by federal rule;

(3) Beginning October 1, 2020, infants under one year of age who are eligible under subdivision (12) of subsection 1 of this section shall be limited to those infants whose family income does not exceed one hundred eighty-five percent of the federal poverty level as converted

to the MAGI equivalent net income standard as established and amended by the federal Department of Health and Human Services or its successor agency. Infants under one year of age born to women who were covered under subdivision (2) of this subsection with family income between one hundred thirty-three and one hundred eighty-five percent of the federal poverty level as converted to the MAGI equivalent net income standard shall only be eligible if, in addition to the other requirements, his or her parents do not have access to health insurance coverage for the child through a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis, and the parents are not eligible for a premium subsidy for the child or family through such exchange because the parents have been determined to have access to affordable health insurance as defined by the exchange;

(4) The changes in eligibility under subdivisions (1) to (3) of this subsection shall not take place unless and until:

(a) There are health insurance premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended, available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis. The director of the department of revenue shall certify to the director of the department of social services that health insurance premium tax credits are available, and the director of the department shall notify the revisor of statutes;

(b) The federal Department of Health and Human Services grants any necessary waivers and state plan amendments to implement this subsection, federal funding is received for the premium subsidies to be paid, and notice has been provided to the revisor of statutes.

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

2002, shall be invalid and void.

[3.**]** **4.** After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for MO HealthNet benefits for four calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for MO HealthNet benefits for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C. 1396r-6. Each family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. 1396r-6 shall receive MO HealthNet benefits without fee for an additional six months. The MO HealthNet division may provide by rule and as authorized by annual appropriation the scope of MO HealthNet coverage to be granted to such families.

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

[5.**]** **6.** The department of social services may apply to the federal Department of Health and Human Services for a MO HealthNet waiver amendment to the Section 1115 demonstration waiver or for any additional MO HealthNet waivers necessary not to exceed one million dollars in additional costs to the state, unless subject to appropriation or directed by statute, but in no event shall such waiver applications or amendments seek to waive the services of a rural health clinic or a federally qualified health center as defined in 42 U.S.C.

1396d(l)(1) and (2) or the payment requirements for such clinics and centers as provided in 42 U.S.C. 1396a(a)(15) and 1396a(bb) unless such waiver application is approved by the oversight committee created in section 208.955. A request for such a waiver so submitted shall only become effective by executive order not sooner than ninety days after the final adjournment of the session of the general assembly to which it is submitted, unless it is disapproved within sixty days of its submission to a regular session by a senate or house resolution adopted by a majority vote of the respective elected members thereof, unless the request for such a waiver is made subject to appropriation or directed by statute.

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

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

208.186. 1. Any person participating in the MO HealthNet program who has pled guilty to or been found guilty of a crime involving alcohol or a controlled substance or any crime in which alcohol or substance abuse was, in the opinion of the court, a contributing factor to the person's commission of the crime shall be required to obtain an assessment by a treatment provider approved by the department of mental health to determine the need for services. Recommendations of the treatment provider may be used by the court in sentencing.

2. Any person participating in the MO HealthNet program who is a parent of a child subject to proceedings in juvenile court under subsection 1 or 2 of section 211.031, whose misuse of controlled substances or alcohol is found to be a significant, contributing factor to the reason the child was adjudicated, shall be required to obtain an

assessment by a treatment provider approved by the department of mental health to determine the need for services. Recommendations of the treatment provider shall be included in the child's permanency plan. The court may order the parent or guardian to successfully complete treatment before the child is reunified with the parent or guardian.

3. The MO HealthNet division shall certify a MO HealthNet participant's enrollment in MO HealthNet if requested by the court under this section. A letter signed by the director of the MO HealthNet division or his or her designee or the family support division certifying that the individual is a participant in the MO HealthNet program shall be prima facie evidence of such participation and shall be admissible into evidence without further foundation for that purpose. The letter may specify additional information such as anticipated dates of coverage as may be deemed necessary by the department.

208.631. 1. Notwithstanding any other provision of law to the contrary, the MO HealthNet division shall establish a program to pay for health care for uninsured children. Coverage pursuant to sections 208.631 to 208.659 is subject to appropriation. The provisions of sections 208.631 to 208.569, health care for uninsured children, shall be void and of no effect if there are no funds of the United States appropriated by Congress to be provided to the state on the basis of a state plan approved by the federal government under the federal Social Security Act. If funds are appropriated by the United States Congress, the department of social services is authorized to manage the state children's health insurance program (SCHIP) allotment in order to ensure that the state receives maximum federal financial participation. Children in households with incomes up to one hundred fifty percent of the federal poverty level may meet all Title XIX program guidelines as required by the Centers for Medicare and Medicaid Services. Children in households with incomes of one hundred fifty percent to three hundred percent of the federal poverty level shall continue to be eligible as they were and receive services as they did on June 30, 2007, unless changed by the Missouri general assembly.

2. For the purposes of sections 208.631 to 208.659, "children" are persons up to nineteen years of age. "Uninsured children" are persons up to nineteen years of age who are emancipated and do not have access to affordable employer-subsidized health care insurance or other health care coverage or

persons whose parent or guardian have not had access to affordable employer-subsidized health care insurance or other health care coverage for their children for six months prior to application, are residents of the state of Missouri, and have parents or guardians who meet the requirements in section 208.636. A child who is eligible for MO HealthNet benefits as authorized in section 208.151 is not uninsured for the purposes of sections 208.631 to 208.659.

3. Beginning October 1, 2020, a child eligible under sections 208.631 to 208.658 shall only remain eligible if, in addition to the other requirements, his or her parents do not have access to health insurance coverage for the child through their employment or through a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis because the parents are not eligible for a premium subsidy for the child or family through such exchange. This subsection shall not go into effect unless and until, for a six-month period preceding the additional requirements, there are health insurance premium tax credits available for children and family coverage under Section 36B of the Internal Revenue Code of 1986, as amended, available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis, which have been in place for a six-month period.

4. The department shall inform participants six months prior to coverage being discontinued under subsection 3 of this section as to the possibility of insurance coverage through the purchase of a subsidized health insurance plan available through a health care exchange.

208.661. 1. The department shall develop incentive programs, submit state plan amendments and apply for necessary waivers to permit rural health clinics, federally-qualified health centers, or other primary care practices to co-locate on the property of public elementary and secondary schools with fifty percent or more students who are eligible for free or reduced price lunch.

2. No school-based health care clinic established under this section shall perform or refer for abortion services, or provide or refer for contraceptive drugs or devices.

3. The consent of a parent or legal guardian shall be required before a minor may receive health care services under this section.

4. The provisions of this section shall be null and void unless and

until any waivers necessary to the implementation of subsections 2 and 3 of this section are granted by the federal government.

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

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

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

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

5. Coverage for the child shall continue for up to one year after

birth, unless otherwise prohibited by law or unless otherwise limited by the general assembly through appropriations.

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

7. The department may provide coverage for an unborn child enrolled in the show-me healthy babies program through:

(1) Direct coverage whereby the state pays health care providers directly or by contracting with a managed care organization or with a group or individual health insurance provider;

(2) A premium assistance program whereby the state assists in payment of the premiums, co-payments, coinsurance, or deductibles for a person who is eligible for health coverage through an employer, former employer, labor union, credit union, church, spouse, other organizations, other individuals, or through an individual health insurance policy that includes coverage for the unborn child, when such person needs assistance in paying such premiums, co-payments, coinsurance, or deductibles;

(3) A combination of direct coverage, such as when the unborn child is first enrolled, and premium assistance, such as after the child is born; or

(4) Any other similar arrangement whereby there:

(a) Are lower program costs without sacrificing health care coverage for the unborn child or the child up to one year after birth;

(b) Are greater covered services for the unborn child or the child up to one year after birth;

(c) Is also coverage for siblings or other family members, including the unborn child's mother, such as by providing pregnancy-related assistance under 42 U.S.C. 1397ll, relating to coverage of targeted low-income pregnant women through the children's health insurance program (CHIP); or

(d) Will be an ability for the child to transition more easily to non-government or less government-subsidized group or individual health insurance coverage after the child is no longer enrolled in the

show-me healthy babies program.

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

9. Within sixty days after the effective date of this section, the department shall submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the show-me healthy babies program.

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

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

(2) The efficacy in providing services to unborn children through managed care organizations, group or individual health insurance providers or premium assistance, or through other nontraditional arrangements of providing health care;

(3) The change in the proportion of unborn children who receive care in the first trimester of pregnancy due to a lack of waiting periods, by allowing presumptive eligibility, or by removal of other barriers, and any resulting or projected decrease in health problems and other problems for unborn children and women throughout pregnancy; at labor, delivery, and birth; and during infancy and childhood;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

best practices and shall report such findings to the oversight committee.

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

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

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

[6.**]** **5.** The department of social services shall engage in a public process for the design, development, and implementation of the health improvement plans and other aspects of MO HealthNet. Such public process shall allow for but not be limited to input from consumers, health advocates, disability advocates, providers, and other stakeholders.

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

[8.**]** **7.** For any necessary contracts related to the purchase of products or

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

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

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

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

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

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

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

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

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

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

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

4. **[**Nothing in this section shall be construed as authorizing the committee to hire employees or enter into any employment contracts**] The committee is authorized to hire an employee or enter into employment**

contracts. The compensation of such personnel and the expenses of the committee shall be paid from the joint contingent fund or jointly from the senate and house contingent funds until an appropriation is made therefor.

5. **[**The committee shall receive and study the five-year rolling MO HealthNet budget forecast issued annually by the legislative budget office.

6.**]** The committee shall **annually conduct a rolling five-year MO HealthNet forecast and** make recommendations in a report to the general assembly by January first each year, beginning in **[**2008**] 2015**, on anticipated growth in the MO HealthNet program, needed improvements, anticipated needed appropriations, and suggested strategies on ways to structure the state budget in order to satisfy the future needs of the program.

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

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

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

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

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

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

3. The department, or family support division, shall conduct electronic searches to redetermine eligibility on the basis of income, residency, citizenship, identity and other criteria as described in 42 CFR 435.916 upon availability of

federal, state, and commercially available electronic data sources. The department, or family support division, may enter into a contract with a vendor to perform the electronic search of eligibility information not disclosed during the application process and obtain an applicable case management system. The department shall retain final authority over eligibility determinations made during the redetermination process.

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

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

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

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

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

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

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

6. The MO HealthNet program shall not provide MO HealthNet coverage to a parent or other caretaker relative living with a dependent child unless the child is receiving benefits under the MO HealthNet program, the Children's Health Insurance Program (CHIP)

under 42 CFR Chapter IV, Subchapter D, or otherwise is enrolled in minimum essential coverage as defined in 42 CFR 435.4.

7. As MO HealthNet or other expenditures are reduced or savings achieved pursuant to the eligibility requirements under subsection 2 of section 208.151 and subsection 3 of section 208.631, the portion of the state share of those expenditures that is funded by provider taxes described in 42 CFR 433.56 shall be credited or otherwise shall accrue to the depository account in which the proceeds of such a provider tax are deposited.

208.991. 1. For purposes of this section and **[**section**]** **sections** 208.990 **to 208.998 and section 208.1503**, the following terms mean:

(1) **"Caretaker relative", a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, which may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes, and who is one of the following:**

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

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

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

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

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

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

(a) Any foreign earned income or housing costs;

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

(c) Tax-exempt Social Security income;

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

(7) "Medically frail", individuals with:

(a) Serious emotional disturbances;

(b) Disabling mental disorders;

(c) Substance use disorders or chronic medical conditions who are at high risk for significant medical and social costs;

(d) Serious and complex medical conditions, including children who are deemed medically complex;

(e) Physical or mental disabilities that significantly impair the person's ability to perform one or more activities of daily living; or

(f) An adjudicated level of care of twenty-one points or greater as determined by the screening process under 42 CFR 483.100 to 483.138, or deemed eligible for skilled nursing facility placement, but who are not currently residing in a nursing facility.

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

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

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

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

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

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

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

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

(h) CHIP-eligible children; and

(i) Uninsured women as provided in section 208.659.

(2) Effective January 1, 2014, the department shall determine eligibility for individuals eligible for MO HealthNet under subdivision (1) of this subsection based on the following income eligibility standards, unless and until they are changed **under subsection 2 of section 208.151**:

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

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

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

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

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

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

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

208.997. 1. By January 1, 2015, the MO HealthNet division shall develop and implement the "Health Care Homes Program" as a provider-directed care coordination program for MO HealthNet participants who

shall be transitioned from the fee-for-service program to an accountable care organization under section 208.1503. The health care homes program shall provide payment to primary care clinics for care coordination for individuals who are deemed medically frail. Clinics shall meet certain criteria, including but not limited to the following:

(1) The capacity to develop care plans;

(2) A dedicated care coordinator;

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

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

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

3. The health care home for recipients of MO HealthNet services defined in paragraph (f) of subdivision (7) of subsection 1 of section 208.991 shall be the primary provider of home- and community-based services received by the recipient if such provider has a qualified, licensed designee to serve as the recipient's care coordinator and the provider can demonstrate the ability to meet the requirements in subsections 1 and 2 of this section. The qualifications for such designees shall be defined by the department by rule.

4. Providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems and screening and brief intervention shall be reimbursed for utilizing the behavior assessment and intervention, and screening and brief intervention reimbursement codes 96150 to 96155 and 99408 to 99409 or their successor codes under the Current Procedural Terminology (CPT) coding system. Location of service may be limited to NCQA Level 3 Patient-Centered Medical Homes and CARF-accredited health homes.

5. The department may designate that the health care homes program be administered through an organization with a statewide primary care presence, experience with Medicaid population health

management, and an established health care homes outcomes monitoring and improvement system.

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

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

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

208.998. 1. The department of social services shall seek a state plan amendment to extend the current MO HealthNet managed care program statewide by January 1, 2015, for all eligibility groups currently enrolled in a managed care plan as of January 1, 2014. Such eligibility groups shall receive covered services through health plans offered by managed care entities which are authorized by the department. Participants in a plan under this section shall choose a primary care provider. Health plans authorized by the department:

(1) Shall resemble commercially available health plans while complying with federal Medicaid requirements as authorized by federal law or through a federal waiver, and shall consist of managed care organizations paid on a capitated basis;

(2) Shall promote, to the greatest extent possible, the opportunity for children and their parents to be covered under the same plan;

(3) Shall offer plans statewide;

(4) Shall include cost sharing for outpatient services to the maximum extent allowed by federal law;

(5) May include other co-payments and provide incentives that encourage and reward the prudent use of the health benefit provided;

(6) Shall encourage access to care through provider rates that include pay-for-performance and are comparable to commercial rates. The department of social services shall determine pay-for-performance provisions that managed care organizations shall execute and shall provide incentives for managed care organizations that perform well;

(7) Shall provide incentives, including shared risk and savings, to health plans and providers to encourage cost-effective delivery of care;

(8) Shall provide incentive programs for participants to encourage healthy behaviors and promote the adoption of healthier personal habits including limiting tobacco use or behaviors that lead to obesity;

(9) May provide multiple plan options and reward participants for choosing a low-cost plan; and

(10) Shall include the services of health providers as defined in 42 U.S.C. Section 1396d(l)(1) and (2) and meet the payment requirements for such health providers as provided in 42 U.S.C. Sections 1396a(a)(15) and 1396a(bb).

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

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

4. The department shall establish a competitive bidding process for contracting with managed care plans.

(1) The department shall solicit bids only from bidders who offer, or through an associated company offer, an identical or substantially similar plan, in services provided and network, within a health care exchange in this state, whether federally facilitated, state based, or operated on a partnership basis. The bidder, if the bidder offers an identical or similar plan, in services provided or network, or the bidder and the associated company, if the bidder has formed a partnership for purposes of its bid, shall include a process in its bid by which MO

HealthNet recipients who choose its plan will be automatically enrolled in the corresponding plan offered within the health care exchange if the recipient's income increases resulting in the recipient's ineligibility for MO HealthNet benefits. The bidder also shall include in its bid a process by which an individual enrolled in an identical or substantially similar plan, in services provided or network, within a health care exchange in this state, whether federally facilitated, state based, or operated on a partnership basis whose income decreases resulting in eligibility for MO HealthNet benefits shall be enrolled in MO HealthNet after an application is received and the participant is determined eligible for MO HealthNet benefits.

(2) The department shall select a minimum of three winning bids and may select up to a maximum number of bids equal to the quotient derived from dividing the total number of participants anticipated by the department in a region by one hundred thousand.

(3) The department shall accept the lowest conforming bid. For determining other accepted bids, the department shall consider the following factors:

(a) The cost to Missouri taxpayers;

(b) The extent of the network of health care providers offering services within the bidder's plan;

(c) Additional services offered to recipients under the bidder's plan;

(d) The bidder's history of providing managed care plans for similar populations in Missouri or other states;

(e) Any other criteria the department deems relevant to ensuring MO HealthNet benefits are provided to recipients in such manner as to save taxpayer money and improve health outcomes of recipients.

5. Any managed care organization that enters into a contract with the state to provide managed care plans shall be required to fulfill the terms of the contract and provide such plans for at least twelve months, or up to three years if the contract so provides. The state shall not increase the reimbursement rate provided to the managed care organization during the contract period above the rate included in the contract. If the managed care organization breaches the contract, the state shall be entitled to bring an action against the managed care organization for any remedy allowed by law or equity and shall also

recover any and all damages provided by law, including liquidated damages in an amount determined by the department during the bidding process. Nothing in this subsection shall be construed to preclude the department or the state of Missouri from terminating the contract as specified in the terms of the contract, including for breach of contract, lack of appropriated funds, or exercising any remedies for breach as may be provided in the contract.

6. (1) Participants enrolling in managed care plans under this section shall have the ability to choose their plan. In the enrollment process, participants shall be provided a list of all plans available ranked by the relative actuarial value of each plan. Each participant shall be informed in the enrollment process that he or she will be eligible to receive a portion of the amount saved by Missouri taxpayers if he or she chooses a lower cost plan offered in his or her region. The portion received by a participant shall be determined by the department according to the department's best judgment as to the portion which will bring the maximum savings to Missouri taxpayers.

(2) If a participant fails or refuses to choose a plan as set forth in subdivision (1) of this subsection, the department shall determine rules for auto-assignment, which shall include incentives for low-cost bids and improved health outcomes as determined by the department. Auto-enrolled participants shall be assigned to the highest performing managed care organization.

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

8. All MO HealthNet plans under this section shall provide coverage for the following services:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

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

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

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

(10) Pediatric services, including oral and vision care; and

(11) Any other services required by federal law.

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

10. The MO HealthNet managed care program shall provide a high deductible health plan which shall include:

(1) A minimum deductible of one thousand dollars;

(2) After meeting a one thousand dollar deductible, coverage for benefits as specified by rule of the department;

(3) An account, funded by the department, of at least one thousand dollars per adult to pay medical costs for the initial deductible funded by the department;

(4) Preventive care, as defined by the department by rule, that is not subject to the deductible and does not require a payment of moneys from the account described in subdivision (2) of this subsection;

(5) A basic benefits package if annual medical costs exceed one thousand dollars;

(6) As soon as practicable, the establishment and maintenance of a record-keeping system for each health care visit or service received by recipients under this subsection. The plan shall require that the recipient's prepaid card number be entered, or electronic strip be swiped, by the health care provider for purposes of maintaining a record of every health care visit or service received by the recipient from such provider, regardless of any balance on the recipient's card. Such information shall include only the date, provider name, and general description of the visit or service provided. The plan shall maintain a complete history of all health care visits and services for which the recipient's prepaid card is entered or swiped in accordance with this subdivision. If required under the federal Health Insurance Portability and Accountability Act (HIPAA) or other relevant state or federal law or regulation, a recipient shall, as a condition of participation in the prepaid card incentive, be required to provide a written waiver for disclosure of any information required under this

subdivision;

(7) The determination of a proportion of the amount left in a participant's account described in subdivision (2) of this subsection which shall be paid to the participant for saving taxpayer money. The amount and method of payment shall be determined by the department; and

(8) The determination of a proportion of a participant's account described in subdivision (2) of this subsection which shall be used to subsidize premiums to facilitate a participant's transition from health coverage under MO HealthNet to private health insurance based on cost-effective principles determined by the department.

11. All participants with chronic conditions, as specified by the department, shall be included in an incentive program for MO HealthNet participants who obtain specified primary care and preventive services, and who participate or refrain from participation in specified activities to improve the overall health of the participant. Participants who complete the requirements of the program shall be eligible to receive an annual cash payment for successful completion of the program. The department shall establish, by rule, the specific primary care and preventive services, activities to be included in the incentive program and the amount of any annual cash payments to participants.

12. A MO HealthNet managed care recipient under this section shall be eligible for participation in only one of either the high deductible health plan under subsection 10 of this section or the incentive program under subsection 11 of this section.

13. No cash payments, incentives, or credits paid to or on behalf of a MO HealthNet participant under a program established by the department under this section shall be deemed to be income to the participant in any means-tested benefit program unless otherwise specifically required by law or rule of the department.

14. Managed care entities shall inform participants who choose the high deductible health plan under subsection 10 of this section that the participant may lose his or her incentive payment under subdivision (7) of subsection 10 of this section if the participant utilizes visits to the emergency department for non-emergent purposes. Such information shall be included on every electronic and paper

correspondence between the managed care plan and the participant.

15. The department shall seek all necessary waivers and state plan amendments from the federal Department of Health and Human Services necessary to implement the provisions of this section. The provisions of this section shall not be implemented unless such waivers and state plan amendments are approved. If this section is approved in part by the federal government, the department is authorized to proceed on those sections for which approval has been granted.

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

208.999. Subject to appropriations, the department shall develop incentive programs to encourage the construction and operation of urgent care clinics which operate outside normal business hours and are in or adjoining emergency room facilities which receive a high proportion of patients who are participating in MO HealthNet, to the extent that the incentives are eligible for federal matching funds.

208.1500. 1. Managed care organizations shall be required to provide to the department of social services, on at least a quarterly basis, and the department of social services shall publicly report the information within thirty days of receipt, including posting on the department's website, at least the following information:

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

(2) Medical loss ratios of each of a managed care organization's capitated specialized subcontractors, such as mental health or dental

health, to make sure that the subcontractors' own administrative costs are not erroneously deemed to be expenditures on health care; and

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

2. Managed care organizations shall be required to maintain medical loss ratios of at least eighty-five percent for Medicaid operations. If a managed care organization's medical loss ratio falls below eighty-five percent in a given month, the managed care plan shall be required to refund to the state the portion of the capitation rates paid to the managed care plan in the amount equal to the difference between the plan's medical loss ratio and eighty-five percent of the capitated payment to the managed care organization.

3. The department of social services shall be required to ensure that managed care organizations establish and maintain adequate provider networks to serve the Medicaid population and to include these standards in its contracts with managed care organizations. Managed care organizations shall be required to establish and maintain health plan provider networks in geographically accessible locations in accordance with travel distances specified by the department of social services in its managed care contracts and as required by the department of insurance, financial institutions and professional registration.

4. Managed care plans' networks must consist of, at minimum, hospitals, physicians, advanced practice nurses, behavioral health providers, substance abuse providers, dentists, emergent and non-emergent transportation services, federally qualified health centers, rural health centers, women's health specialists, local public health agencies, and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified by the department of social services.

5. Managed care organizations shall be required to post all of their provider networks online and shall regularly update their postings of these networks on a timely basis regarding all changes to provider networks. A provider who is seeing only existing patients

under a given managed care plan shall not be so listed.

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

7. Inadequacy of provider networks, as determined from the secret shopper surveys or the publication of false or misleading information about the composition of health plan provider networks, may be the basis for contract cancellation or sanctions against the offending managed care organization.

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

9. Managed care organizations shall be required to ensure sufficient access to out-of-network providers, when necessary, to meet the health needs of enrollees in accordance with standards developed by the department of social services and included in the managed care contracts.

10. Managed care organizations shall be required to provide, on

a quarterly basis and for prompt publication, at least the following information related to service utilization, approval, and denial:

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

(2) Data regarding denials and partial denials by managed care organizations or their subcontractors each month for each category of services provided to Medicaid enrollees. Denials include partial denials whereby a requested service is approved but in a different amount, duration, scope, frequency, or intensity than requested; and

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

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

(1) Plan disenrollment data by cause, number of months with the particular managed care plan prior to disenrollment, and form of enrollment, such as passive enrollment or enrollee election;

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

(3) Consumer satisfaction survey data;

(4) Enrollee telephone access reports including the number of unduplicated calls by enrollees, average wait time before managed care organization or subcontractor response, busy signal rate, and enrollee telephone call abandonment rate;

(5) Data regarding the average cost of care of individuals whose care is reported as having been actively managed by the managed care organization versus the average cost of care of the managed care organization's population generally. For purposes of this section, the phrase "actively managed by the managed care organization" means the managed care organization has actually developed a care plan for the particular individual and is implementing it as opposed to reacting to

prior authorization requests as they come in, reviewing usage data, or monitoring doctors with high utilization;

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

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

(8) Provider change data indicating how many enrollees changed their primary care provider by cause, months of enrollment, and form of enrollment, such as passive enrollment or enrollee election;

(9) Any data related to preventable hospitalizations, hospital acquired infections, preventable adverse events, and emergency room admissions; and

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

208.1503. 1. Beginning January 1, 2015, the group of participants in the MO HealthNet fee-for-service program as of January 1, 2014, except for those participants in skilled nursing facilities, shall be transitioned to regionally-based accountable care organizations. For purposes of this section, an "accountable care organization" or "ACO" shall mean an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of a defined group of MO HealthNet participants.

2. The department shall engage a wide range of community stakeholders to design an ACO that functions well to meet a variety of needs. The regional ACOs shall be full-risk bearing entities reimbursed through a global payment methodology developed by the department. Participants under an ACO shall be placed in a health care home under section 208.997 or in the disease management 3700 project (DM 3700) or any successor collaborative project between the

department of mental health and MO HealthNet that targets high cost MO HealthNet participants who have co-occurring chronic medical conditions and serious mental illness.

3. Notwithstanding MO HealthNet coverage of children under section 208.998, the department shall advance the development of systems of care for medically complex children who are recipients of MO HealthNet benefits by accepting cost-effective regional proposals from and contracting with appropriate pediatric care networks, pediatric centers for excellence, and medical homes for children to provide MO HealthNet benefits when the department determines it is cost effective to do so. Such entities shall be treated as accountable care organizations under this section.

4. The department shall promulgate rules to implement this section, including rules that:

(1) Encourage access to care through provider rates that include pay-for-performance and are comparable to commercial rates;

(2) Develop statewide uniform data and analytics integration;

(3) Consider developing regional community care organizations as an ACO model for the introduction of the elderly, blind and disabled population into coordinated care;

(4) Require the contracts to adopt mandatory medical loss ratios;

(5) The reforms should include risk-sharing arrangements between ACOs and payers;

(6) Sponsor a variety of community collaboration initiatives to promote cost-saving and health improvement activities at the local level;

(7) Ensure that there is an adequate provider network through the ACO agreements.

208.1506. 1. Notwithstanding any other provision of law to the contrary, beginning July 1, 2015, any MO HealthNet recipient who elects to receive medical coverage through a private health insurance plan instead of through the MO HealthNet program shall be eligible for a private insurance premium subsidy to assist the recipient in paying the costs of such private insurance if it is determined to be cost effective by the department. The subsidy shall be provided on a sliding scale based on income, with a graduated reduction in subsidy over a period of time not to exceed two years.

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

✓