Rules of
Department of Social Services
Division 40—Family Support Division
Chapter 7—Family Healthcare

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Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 7—Family Healthcare

13 CSR 40-7.010 Scope and Definitions

PURPOSE: The purpose of this rule is to define terms that are used in determining eligibility for Family MO HealthNet programs and the Children's Health Insurance Program (CHIP).

(1) For purposes of this chapter, the following definitions shall apply:

(A) "Applicant" is the adult who completes and submits an application for a Family MO HealthNet Program or CHIP program, whether for themselves or on behalf of someone else;

(B) "Child" or "Children" means a person or persons who are under nineteen (19) years of age;

(C) "Children's Health Insurance Program" or "CHIP" means the health assistance provided to uninsured, low income children under Title XXI of the Social Security Act and established in sections 208.631 through 208.658, RSMo;

(D) "Division" means the Family Support Division, Department of Social Services;

(E) "Electronic data hub" means any electronic service established by the Secretary of the United States Department of Health and Human Services, through which the division may verify certain information with, or obtain such information from, federal agencies and other data sources;

(F) "Family Mo HealthNet programs" means MO HealthNet benefits provided to participants under the MO HealthNet for Families (MHF) program, MO HealthNet for Kids (MHK) program, MO HealthNet for Pregnant Women (MPW) program, and Uninsured Woman's Health Services (UWHS) program. Family MO HealthNet programs also include presumptive eligibility for any of the above programs;

(G) "Non-custodial parent" means the parent who does not have physical custody of the child.

1. If physical custody is questioned, a court order, judgment, decree, or any legally enforceable separation, divorce, or custody agreement establishing which party has physical custody shall control who is the custodial parent;

2. If there is no such order or agreement, or the order or agreement is silent, or in the event of joint custody, the custodial parent is the parent with whom the child expects to spend more than fifty percent (50%) of his or her overnight visits in the year for which eligibility is being determined; or

3. In the case of true joint physical custody where the child spends an equal amount of overnight visits with both parents, the non-custodial parent is the parent who does not claim the child as part of their tax household;

(H) "Parent" means a natural or biological, adopted, or stepparent;

(I) "Participant" means any individual who has applied for, is receiving, or has been denied Family MO HealthNet benefits or CHIP benefits;

(J) "Sibling" means a natural or biological, adopted, half, or step sibling;

(K) "Reasonable Compatibility" means the information received by the division, is not in conflict with other information known by the division. Income information is "reasonably compatible" if the sources of information are above or both are at or below the applicable income standard or other relevant income threshold limit, or the difference between the sources of the income information is ten percent (10%) or less and the sources of income are similar;

(L) "Tax Dependent" means an individual for whom another individual claims a deduction for a personal exemption under *Internal Revenue Code*, section 151 for a taxable year; and

(M) "Taxpayer" means an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made and who does not expect to be claimed as a tax dependent by another individual.

AUTHORITY: section 207.020, RSMo 2000, and section 208.991, RSMo Supp. 2013. Original rule filed July 31, 2013, effective Feb. 28, 2014.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993 and 208.991, RSMo 2013.*

13 CSR 40-7.015 Application Procedure for Family MO HealthNet Programs and the Children's Health Insurance Program (CHIP)

PURPOSE: This rule defines the application procedures for Family MO HealthNet programs or the Children's Health Insurance Program (CHIP).

(1) General application procedures for programs administered by the Family Support Division are found at 13 CSR 40-2.010. For anything in this section conflicting with the general application procedures, this regulation controls for the application procedures for Family MO HealthNet programs or the Children's Health Insurance Program (CHIP).

(2) An application for Family MO HealthNet programs or the Children's Health Insurance Program (CHIP) may be obtained by contacting one (1) of the following sources:

(A) An insurance exchange, whether federally facilitated, state based, or operated on a partnership basis;

(B) The Family Support Division Contact Center;

(C) A Family Support Division office; or

(D) Accessing the Department of Social Services website www.dss.mo.gov.

(3) An application for Family MO HealthNet program or the Children's Health Insurance Program (CHIP) shall be accepted by mail, telephone, or in person at any Family Support office, or via the department's Internet website found at www.dss.mo.gov. The division shall also accept applications through providers who the division contracts with in order to facilitate eligibility decisions.

(4) The following individuals may apply for Family MO HealthNet or the Children's Health Insurance Program (CHIP) on behalf of a participant:

(A) The participant, as defined under 13 CSR 40-7.010;

(B) An adult who is in the participant's household. For purposes of this subsection, "household" shall have the same definition as in 42 CFR section 435.603(f)(1);

(C) A member of the participant's family, as defined in 26 U.S.C section 36B(d)(1);

(D) An authorized representative of the participant;

(E) An individual with a valid power of attorney to act on behalf of the participant;

(F) If the participant is an incapacitated person as defined under 475.010, RSMo—

1. A parent, spouse, and other close adult relative;

2. An authorized representative; or

3. A guardian or conservator; or

4. A public administrator; or

5. Other person appointed by a court of competent jurisdiction.

(G) If the participant is a minor under age eighteen (18), an application may be submitted by the following:

1. The minor on behalf of him/herself, if any of the following conditions apply:

A. The minor is pregnant;

B. The minor has been lawfully married;

C. The minor is a parent;

D. The minor is a victim of domestic violence, as defined by section 455.010, RSMo, or meets all the criteria in section

431.056, RSMo;

E. Is a victim of trafficking offenses under section 566.203, 566.206, 566.209, 566.210, or 566.211, RSMo; or

F. The minor is emancipated.

2. For other minors not in the custody, care, or control of a parent or guardian, someone acting responsibly for the applicant. This shall include a person age eighteen (18) or over who has the capacity to enter into a contract, has primary custody, care, or control of the minor and who—

A. Is related to the applicant by blood, marriage, or adoption; or

B. Is a person who—

(I) The division reasonably determines has sufficient knowledge of the applicant's circumstances to accurately complete the application; and

(II) Has an obligation to act in the best interests of the applicant as per 13 CSR 40-2.015.

(5) The applicant shall provide and attest to the following information when making an application for Family MO HealthNet benefits or CHIP benefits:

(A) The name of each individual who resides with the participant;

(B) The name of each individual who the participant claims or intends to claim on his or her federal income tax returns;

(C) The name of any person who claims or intends to claim the participant as a dependent on his or her federal tax forms; and

(D) For the participant, and each person listed in subsections (5)(A), (5)(B), or (5)(C), the applicant shall provide the following information:

1. Relationship to the applicant;
2. Physical Address;
3. Mailing address, if different from physical address;
4. Date of Birth;
5. Gender;
6. Social Security Number, in accordance with section (6) of this rule;
7. Intent to file taxes or be claimed as a tax dependent on someone else's taxes;
8. Whether the participant is pregnant;
9. Any physical, mental, or emotional health condition that causes limitations in activities of daily living;
10. Residence in a medical facility or nursing home;
11. Citizenship or immigration status;
12. Race (optional);
13. Employment status, employer name and address, hours employed, and rate of pay;
14. Any and all sources of income and amounts;
15. Any federal tax deductions entitled for alimony paid or student loan interest;
16. Enrollment in any health care coverage, name of insurer, policy number, and any limitations on the coverage;
17. If he or she or anyone in their family is American Indian or Alaska Native. If any person is, information about tribe affiliation, services, and income received from benefits must be disclosed;
18. Details concerning any health coverage which is available to him or her through a job. This includes coverage that is offered through someone else's job, such as a parent or spouse; and
19. If a participant is a child, the name and address of any parent living outside the home.

(6) Subject to the exceptions recognized in 42 CFR 435.910(h), Social Security numbers are requested of every person for whom coverage is being requested, pursuant to subsections (5)(A), (5)(B), or (5)(C).

(A) If the person is a participant in MO HealthNet, the person's Social Security number shall be included.

(B) If the person is not a participant in MO HealthNet, the inclusion of the Social Security number is voluntary.

(C) Social Security numbers are to be used only for the purpose of determining a participant's eligibility for MO HealthNet or for a purpose directly connected to the administration of MO HealthNet.

(7) The applicant shall sign an assignment of rights to the MO HealthNet Division to pursue and recover money owed for medical expenses from any applicable insurance policies, legal settlements or judgments, or other liable or potentially liable third parties.

(8) The applicant shall sign an assignment of rights to pursue and obtain medical support from a parent or spouse who owes such a duty.

(9) The participant and applicant shall disclose all information which may impact eligibility for any MO HealthNet program. The participant and applicant have a continuing obligation to notify the division if any information specified in the application changes within ten (10) days of the change. The continuing duty includes, but is not limited to disclosing any changes in income of the participant or household member, changes in residence or mailing address, and the addition or removal of any individual from the household whose information is or was required to be submitted.

(10) The applications shall be signed under penalty of perjury, attesting to the information provided as true, accurate, and complete.

AUTHORITY: sections 207.022, 208.991, and 660.017, RSMo 2016. Original rule filed July 31, 2013, effective Feb. 28, 2014. Amended: Filed April 18, 2018, effective Nov. 30, 2018.*

**Original authority: 207.022, RSMo 2014; 208.991, RSMo 2013; and 660.017, RSMo 1995.*

13 CSR 40-7.020 Household Composition

PURPOSE: The purpose of this rule is to explain the Household Composition Standard for Family MO HealthNet programs and the Children's Health Insurance Program (CHIP).

(1) A household shall include the taxpayer, or in the case of a joint return, taxpayers, and all tax dependents.

(A) In the case of a married couple living together, each spouse shall be included in the household of the other spouse regardless of whether they expect to file jointly or whether one (1) spouse is expected to be declared as a tax dependent of the other spouse.

(B) In determining the household size of a pregnant woman, the division shall count the pregnant woman plus the number of unborn children she is expecting to deliver. In determining the household size of other individuals who have a pregnant woman in the household the pregnant woman is considered as one (1) person.

(C) If a taxpayer cannot reasonably establish that another individual is a tax dependent for the tax year for which eligibility is sought, the inclusion of such individual in the household shall be determined in accordance with section (3) of this rule.

(2) In the case of a participant who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the participant's household is the household of the taxpayer claiming such individual as a tax dependent with the following exceptions:

(A) Family members and unrelated individuals claimed as a tax dependent by a taxpayer other than a parent or spouse;

(B) Children claimed as a tax dependent by the non-custodial parent; or

(C) Children who expect to be claimed by one (1) parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return.

(3) For participants who do not expect to file a tax return, who do not intend to be claimed

as a tax dependent, or tax dependents that fall into an exception under subsections (2)(A), (2)(B), or (2)(C) of this rule, the household shall consist of—

(A) The participant;

(B) The spouse of the participant if living with the participant;

(C) Children of the participant if living with the participant; and

(D) For participants who are children—

1. The participant's parents who live with the participant;

2. Any siblings, who are also dependent children, who live with the participant.

(4) This rule shall be effective for all eligibility decisions made on January 1, 2014, and any date after.

AUTHORITY: section 207.020, RSMo 2000, and section 208.991, RSMo Supp. 2013. Original rule filed July 31, 2013, effective Feb. 28, 2014.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993 and 208.991, RSMo 2013.*

13 CSR 40-7.030 Calculation of Modified Adjusted Gross Income (MAGI)

PURPOSE: The purpose of this rule is to explain how Modified Adjusted Gross Income (MAGI) is calculated for the Family MO HealthNet programs and the Children's Health Insurance Program (CHIP).

(1) Modified Adjusted Gross Income (MAGI) based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the *Internal Revenue Code*, with the exceptions listed below.

(A) Any lump sum gift or income is included as income only in the month in which it is received.

(B) Scholarships and grants which are used for educational purposes, and not for living expenses are excluded from income.

(C) The following Alaskan Native and American Indian benefits and distributions are excluded from income:

1. Distributions from Alaska Native Corporations and Settlement Trusts;

2. Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior;

3. Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resources extraction and harvest from—

A. Rights of ownership or possession in any lands described in paragraph (1)(C)2. of this rule; or

B. Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

4. Distributions resulting from real property ownership interests related to natural resources and improvements:

A. Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or

B. Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

5. Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom; and

6. Student financial assistance provided under the Bureau of Indian Affairs education programs.

(2) Eligibility determinations for participants for Family MO HealthNet programs and CHIP shall be based on a household's current monthly income and household size. A household's income is the sum of the Modified Adjusted Gross Income (MAGI) based income as defined above of every individual included in the participant's household.

(A) The division shall take into consideration reasonable anticipated changes in income that exist at initial determination such as seasonal or time based employment sources and periods, or the known ending period of employment or an income source.

(B) Income of a child shall not be included in the household if the child is not required to file a tax return under the *Internal Revenue Code*, section 6012(a)(1) for the taxable year in which eligibility is being determined, regardless if the child expects to or actually filed a tax return.

(3) This rule shall be effective for all eligibility decisions made on January 1, 2014, or any date after.

AUTHORITY: section 207.020, RSMo 2000, and section 208.991, RSMo Supp. 2013. Original rule filed July 31, 2013, effective Feb. 28, 2014.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993 and 208.991, RSMo 2013.*

13 CSR 40-7.035 Participant Verification

PURPOSE: This rule outlines how the Department of Social Services will verify participant information in order to administer the Family MO HealthNet programs and Children's Health Insurance Program (CHIP).

(1) Scope: This regulation specifies how the Department of Social Services shall verify participant information in order to administer the Family MO HealthNet programs and CHIP to prevent fraud and insure the integrity of the Family MO HealthNet programs and CHIP.

(2) The "Federally Facilitated Marketplace" is created under section 1321(c)(1) of the Patient Protection and Affordable Care Act of 2010 (Public Law No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152).

(3) The Department of Social Services shall access the electronic data hub, as defined in 13 CSR 40-7.010, to verify information provided by the participant as part of the application process for Family MO HealthNet programs and CHIP. The department shall only verify the following:

(A) Citizenship;

(B) Immigration status;

(C) Income using Internal Revenue Service information;

(D) Income from Title II benefits information from the Social Security Administration;

(E) The number of work quarters from Social Security Administration;

(F) Employment information; and

(G) Confirm current enrollment in a MO HealthNet program.

(4) The Department of Social Services shall also use the electronic data hub to send information on participants who are not eligible for Family MO HealthNet programs and CHIP to the Federal Facilitated Marketplace to verify if the participants qualify for advance payment of premium tax credit; cost-sharing reductions or qualified health plans. The Federally Facilitated Marketplace will use the electronic data hub to send information to the Department of Social Services to verify if participants qualify for Family MO HealthNet programs or CHIP or to verify if a participant is already enrolled in Family MO HealthNet programs or CHIP.

(5) The Department of Social Services will not use, duplicate, or disclose any information used or obtained under this rule to any individual, organization, state or federal agency for any purpose not related to the public assistance benefits administered in whole or in part

by the Department of Social Services as that phrase is defined in section 205.967.1(1), RSMo. All applicable state and federal laws and regulations governing the confidentiality of public assistance programs, health information, and taxpayer information shall govern the use or disclosure of information shared with or obtained from the electronic data hub.

(6) All information used or obtained under this rule, unless otherwise prohibited by this rule, shall be destroyed in accordance with section 208.125, RSMo, unless otherwise required by law.

AUTHORITY: section 208.990, RSMo Supp. 2013. Original rule filed April 8, 2014, effective Oct. 30, 2014.*

**Original authority: 208.990, RSMo 2013.*

13 CSR 40-7.040 Verification Procedures

PURPOSE: The purpose of this rule is to explain what Verification Procedures the Family Support Division will use when determining eligibility for Family MO HealthNet programs and the Children's Health Insurance Program (CHIP).

(1) The division shall verify all eligibility factors, through available means, including information obtained through the electronic data hub, a participant's statements, or other information the division has obtained. Verification shall occur upon application and recertification, and at any other time necessary to verify continued eligibility.

(A) The division shall verify eligibility information of a participant through the electronic data hub.

(B) If the information obtained through the electronic data hub is reasonably compatible with information provided by or on behalf of the participant, the division shall use the participant's information as verification for eligibility.

(C) If reasonably compatible standards are not met, secondary verification is required. Secondary verification may include the following:

1. Other electronic data sources available;

2. Other information, including paper documentation; or

3. A written statement which reasonably explains the discrepancy.

(2) If verification cannot be obtained by the division through the electronic data hub, or if the information is not reasonably compatible with other information provided, the division shall ask for any additional information from or on behalf of the participant needed in order to verify the information.

(A) The participant shall provide the required verification within ten (10) days from the date that the division requests the information in writing.

(B) A participant may request additional time to provide the information. The additional time shall be granted if the participant is making a reasonable effort to obtain the information.

(C) If a participant fails to provide the requested verification within ten (10) days from the date of the written request or fails to obtain additional time to provide the information, the division shall issue an adverse action notice to the participant notifying them that their coverage is denied or their coverage shall terminate ten (10) days from the date of the adverse action notice.

(D) The participant shall be given the right to request a hearing on the issue pursuant to section 208.080, RSMo. Failure on the part of the participant to request a hearing shall result in termination of coverage upon expiration of the adverse action notice.

(3) This rule shall be effective for all eligibility decisions made on January 1, 2014, and any date after.

AUTHORITY: section 207.020, RSMo 2000, and section 208.991, RSMo Supp. 2013. Original rule filed July 31, 2013, effective Feb. 28, 2014.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993 and 208.991, RSMo 2013.*

13 CSR 40-7.050 Presumptive Eligibility

PURPOSE: The purpose of this rule is to establish the conditions under which MO HealthNet eligibility will be temporarily available to certain categories of participants based on preliminary determinations by certain categories of providers.

(1) The department shall provide MO HealthNet benefits to individuals during a period of presumptive eligibility for individuals who have been determined eligible for MO HealthNet benefits on the basis of preliminary information by a presumptive eligibility qualified entity in accordance with this rule.

(2) For the purposes of this rule—

(A) Presumptive eligibility means temporary MO HealthNet benefits for children under the age of nineteen (19) (pursuant to 42 U.S.C. sections 1396a(47) and 1396r-1a and 42 CFR sections 435.1102 and 435.1110), parents and other caretaker relatives (pursuant to 42 CFR sections 435.1103 and 435.1110), former foster care children (pursuant to 42 CFR sections 435.1103 and 435.1110), pregnant women (pursuant to 42 U.S.C. sections 1396a(47) and 1396r-1 and 42 CFR sections 435.1103 and 435.1110), and individuals with breast cancer or cervical cancer (pursuant to 42 U.S.C. sections 1396a(47) and 1396r-1b and 42 CFR sections 435.1103 and 435.1110) allowing them to receive MO HealthNet benefits before they have applied for MO HealthNet benefits through the division;

(B) Qualifying hospital has the same meaning as in 42 CFR 435.1110(b);

(C) Federally qualified health center has the same meaning as in 42 U.S.C. section 1396(l)(2)(B);

(D) Rural health clinic has the same meaning as in 42 U.S.C. section 1395x(aa)(2);

(E) Presumptive eligibility qualified entity means a MO HealthNet provider organization responsible for screening individuals/families regarding presumptive eligibility for MO HealthNet benefits.

1. For presumptive eligibility determinations for children under the age of nineteen (19), presumptive eligibility qualified entity means a federally qualified health center, rural health clinic, or qualifying hospital that meets the requirements for a "qualified entity" in 42 U.S.C. section 1396r–1a(b)(3)(A).

2. For presumptive eligibility determinations for pregnant women, presumptive eligibility qualified entity means a county health department, federally qualified health center, rural health clinic, or qualifying hospital that meets the requirements for a "qualified provider" in 42 U.S.C. section 1396r–1(b)(2).

3. For presumptive eligibility determinations for parents and caretaker relatives, presumptive eligibility qualified entity means a qualifying hospital as provided in section 42 CFR 435.1110.

4. For presumptive eligibility determinations for breast and cervical cancer treatment, presumptive eligibility qualified entity means a Show-Me Healthy Women Provider which has a participation agreement with the Missouri Department of Health and Senior Services that meets the requirements for a "qualified entity" in 42 U.S.C. section 1396r–1b(b)(2).

5. For presumptive eligibility determinations for former foster care children, presumptive eligibility qualified entity means a qualifying hospital.

(3) In order to be eligible to be a presumptive eligibility qualified entity, a MO HealthNet provider must first—

(A) Apply to be a presumptive eligibility qualified entity in a manner prescribed by the division which shall include the following information:

1. The name and mailing address of the MO HealthNet provider applying to be a presumptive eligibility qualified entity;

2. The state in which the provider is licensed, registered, or incorporated;

3. The national provider identifier (NPI) number of the provider;

4. The MO HealthNet programs for which the provider intends to be a presumptive eligibility qualified entity; and

5. The name, mailing address, telephone number, and email address of the individual who will serve as principal contact between the qualified entity and the division with respect to presumptive eligibility determinations;

(B) Be approved as a presumptive eligibility qualified entity by the division;

(C) Through representatives, attend and successfully complete all training required by the division for presumptive eligibility qualified entities;

(D) Comply with section 208.155, RSMo and shall execute agreements, as required by the division, relating to security, confidentiality, and computer access; and

(E) Post an informational poster regarding the availability of MO HealthNet benefits in its facility reception area or in some other appropriate area of the facility if requested to do so by the division.

(4) A presumptive eligibility qualified entity shall make presumptive eligibility determinations subject to the requirements listed below:

(A) Designated staff or other representatives of the presumptive eligibility qualified entity will offer interested individuals/families the opportunity to apply for and receive benefits based on a presumptive eligibility determination;

(B) Designated staff or other representatives of the presumptive eligibility qualified entity will determine presumptive eligibility for the program;

(C) The presumptive eligibility qualified entity shall provide applicable MO HealthNet application forms to individuals, parents, and caretakers pursuant to 13 CSR 40-7.015 and assist such persons in completing and filing such forms, or shall assist individuals, parents, and caretakers to apply at mydss.mo.gov;

(D) The presumptive eligibility qualified entity shall notify the individual, parent, or caretaker of the presumptive eligibility determination in writing at the time the determination is made on a form provided or approved by the division;

(E) The presumptive eligibility qualified entity shall notify the division that the participant is presumptively eligible within five (5) working days after the date of a presumptive eligibility determination;

(F) Where a determination of presumptive eligibility is made, the presumptive eligibility qualified entity shall notify the individual, parent, or caretaker in writing on a form provided or approved by the division, that—

1. If a MO HealthNet application is not filed by the last day of the month following the month in which the presumptive eligibility determination is made, the period of presumptive eligibility will end on that last day; and

2. If a MO HealthNet application is filed by the last day of the month following the month in which the presumptive eligibility determination is made, the period of presumptive eligibility will end on the day a decision is made on the MO HealthNet application;

(G) Where a determination is made that the individual is not presumptively eligible, the presumptive eligibility qualified entity shall notify the individual, parent, or caretaker in writing on a form provided or approved by the division, at the time the determination is made, of the reason for the determination and that the individual, parent, or caretaker may file an application for MO HealthNet benefits pursuant to 13 CSR 40-7.015;

(H) In making a presumptive eligibility determination, the presumptive eligibility qualified entity shall apply preliminary eligibility criteria established by applicable law and regulation, using forms provided by the division, and shall approve an application for presumptive eligibility only if the following requirements are met:

1. For children under the age of nineteen (19)—

A. The child must meet the same requirements for income and United States and Missouri residency required for regular Medicaid coverage for children under nineteen (19); and

B. There can be no more than one (1) presumptive eligibility period within a twelve- (12-) month period starting with the effective date of the initial presumptive eligibility period;

2. For parents and caretaker relatives—

A. Individuals must be parents or other caretaker relatives (as defined in 42 CFR 435.4), including pregnant women, of a dependent child (as defined in 42 CFR 435.4) under age eighteen (18);

B. The individual must meet the same requirements for income and United States and Missouri residency required for regular Medicaid coverage for parents; and

C. There can be no more than one (1) presumptive eligibility period within a twelve- (12-) month period starting with the effective date of the initial presumptive eligibility period;

3. For pregnant women—

A. The individual must be pregnant;

B. The woman must meet the same requirements for income and United States and Missouri residency required for regular Medicaid coverage for pregnant women or for coverage under the Show-Me Healthy Baby program; and

C. The individual must not have already received benefits under a MO HealthNet presumptive eligibility program during the current pregnancy;

4. For breast and cervical cancer treatment—

A. The individual must be diagnosed with breast or cervical cancer by a Show-Me Healthy Women Provider unless the participant is diagnosed by a MO HealthNet provider while currently receiving MO HealthNet benefits;

B. The woman must meet the same requirements for income and United States and Missouri residency required for regular coverage under the Breast and Cervical Cancer Coverage program; and

C. There can be no more than one (1) presumptive eligibility period within a twelve- (12-) month period starting with the effective date of the initial presumptive eligibility period;

5. For former foster care children—

A. The individual must be in foster care under the responsibility of the state of Missouri as of their eighteenth birthday or within thirty (30) days prior to their eighteenth birthday;

B. The individual must be under the age of twenty-six (26) years old;

C. The individual must not be eligible for another MO HealthNet benefits group;

D. The individual must have been covered by MO HealthNet while they were in foster care;

E. The individual must be a Missouri resident; and

F. There can be no more than one (1) presumptive eligibility period within a twelve- (12-) month period starting with the effective date of the initial presumptive eligibility period;

(I) The presumptive eligibility qualified entity shall verify with the division that prospective participants are not currently covered by MO HealthNet or have not already had a period of presumptive eligibility during the past twelve (12) months or, if applicable, during the current pregnancy;

(J) The presumptive eligibility qualified

entity shall adhere to the following application processing procedures established by the division:

1. The presumptive eligibility qualified entity shall date stamp the presumptive eligibility applications and MO HealthNet applications on the same day received if paper applications are used;

2. In connection with presumptive eligibility determinations, the division will provide to presumptive eligibility qualified entity only the applicant's or participant's Departmental Client Numbers (DCN), dates of MO HealthNet coverage, correct spelling of names, correct type of assistance, and level of care. All other requests for applicant or participant information from the presumptive eligibility qualified entity to the division shall be accompanied by an appropriate authorization for release of information;

3. To the extent it receives a completed MO HealthNet application, the presumptive eligibility qualified entity shall transmit MO HealthNet applications to the division for final processing so they are received by the division within five (5) business days of the applicant's or participant's signature;

(K) The presumptive eligibility qualified entity shall maintain written or electronic records of all presumptive eligibility applications and determinations along with any related supporting documentation for a period of five (5) years from the date of the determination or application unless litigation or an audit by the department, State Auditor's Office, or the Center for Medicare and Medicaid Services relating to the records has been started prior to the sixth year, then records must be maintained until the litigation or audit is resolved. These records shall be made available to the department, at its request, for the purposes of determining whether the presumptive eligibility qualified entity is in compliance with this rule;

(L) The presumptive eligibility qualified entity's staff that are, or will be, involved in making presumptive eligibility determinations shall attend or otherwise receive and satisfactorily complete training from the division in the manner prescribed by the division;

(M) The presumptive eligibility qualified entity shall keep up-to-date the identity and contact information of the person who will be the primary contact between the division and the presumptive eligibility qualified entity under paragraph (3)(A)5. of this rule;

(N) The presumptive eligibility qualified entity shall not delegate or subcontract the authority to determine presumptive eligibility to another entity. However, they may implement their presumptive eligibility program with the support of third party contractors.

(5) MO HealthNet benefits begin on the date the presumptive eligibility qualified entity determines that the individual is presumptively eligible. The presumptive eligibility period shall end on the date a decision is made on the individual's MO HealthNet application or, in the event no regular application is filed, on the last day of the month following the month in which the presumptive eligibility determination was made.

(6) After a determination of presumptive eligibility is made, MO HealthNet providers shall provide applicable services during the period the presumptive eligibility determination remains in effect.

(7) In order to remain a presumptive eligibility qualified entity, a presumptive eligibility qualified entity must meet the following performance standards with respect to its presumptive eligibility determinations:

(A) The presumptive eligibility qualified entity must make, and be capable of making, presumptive eligibility determinations in accordance with this rule, including compliance with quality assurance and on-site monitoring efforts by the division;

(B) The division must receive a regular MO HealthNet application for the appropriate program before the end of the presumptive eligibility period with respect to ninety percent (90%) of the participants determined to be presumptively eligible by the presumptive eligibility qualified entity in the aggregate, for each calendar year, and for any shorter review period designated by the division. This standard shall be effective twelve (12) months from the date that the division first approves the qualified entity's application to determine presumptive eligibility;

(C) Ninety-five percent (95%) or more of the applications actually received by the division from participants determined to be presumptively eligible by the presumptive eligibility qualified entity must be approved as eligible for MO HealthNet benefits by the division in the aggregate, for each calendar year, and for any shorter review period designated by the division. This standard shall be effective twelve (12) months from the date that the division first approves the qualified entity's application to determine presumptive eligibility. However, applications denied because the applicant failed to meet eligibility criteria that are not listed in subsection (4)(H) of this rule will not count against the presumptive eligibility qualified entity for the purposes of this performance standard;

(D) The presumptive eligibility qualified entity is required by subsection (4)(I) of this rule to check whether the applicant already has current MO HealthNet coverage. The presumptive eligibility qualified entity shall make this determination of prior coverage accurately with respect to ninety percent (90%) or more of its presumptive eligibility determinations, whether presumptive eligibility is approved or denied, in the aggregate, for each calendar year, and for any shorter review period designated by the division. This standard shall be effective twelve (12) months from the date that the division first approves the qualified entity's application to determine presumptive eligibility;

(E) The presumptive eligibility qualified entity is required by subsection (4)(I) of this rule to check whether the applicant has received MO HealthNet benefits under presumptive eligibility in the past twelve (12) months or, for pregnancy determinations, during the current pregnancy. The presumptive eligibility qualified entity shall make this determination correctly with respect to ninety-eight percent (98%) or more of its presumptive eligibility applicants, whether presumptive eligibility is approved or denied, in the aggregate, for each calendar year, and for any shorter review period designated by the division. This standard shall be effective twelve (12) months from the date that the division first approves the qualified entity's application to determine presumptive eligibility;

(F) The presumptive eligibility qualified entity shall make an accurate presumptive eligibility determination based on the information provided from the applicant on the presumptive eligibility application on ninety percent (90%) of its presumptive eligibility applicants, whether presumptive eligibility is approved or denied, in the aggregate, for each calendar year, and for any shorter review period designated by the division. This standard shall be effective twelve (12) months from the date that the division approves the qualified entity's application to determine presumptive eligibility;

(G) In the event a presumptive eligibility qualified entity fails to meet any of the standards set forth in subsections (7)(A) through (7)(F), the presumptive eligibility qualified entity, upon notification by the division that it has not met the standard(s), shall submit to the division a corrective action plan to ensure future compliance with subsections (7)(A) through (7)(F). The presumptive eligibility qualified entity must amend the corrective action plan as required by the division. Once the division has approved the corrective action plan, the qualified entity must implement and satisfactorily complete the corrective action plan within the time frames set forth in the plan. The division shall monitor the qualified entity's performance on the corrective action plan at least every three (3)

months until the division determines that the corrective action plan has been successfully completed;

(H) In the event the presumptive eligibility qualified entity does not submit a corrective action plan acceptable to the division or again fails to meet the performance standards set forth in subsections (7)(A) through (7)(F) after approval by the division of a corrective action plan, the division may disqualify the provider as a presumptive eligibility qualified entity.

1. The qualified entity shall receive thirty (30) days prior notice of its disqualification as a presumptive eligibility qualified entity.

2. The presumptive eligibility qualified entity shall have ten (10) calendar days after receipt of a notice of disqualification to submit a request that the department director reconsider the decision to disqualify. Any such request for reconsideration shall include a detailed explanation of the reasons why the presumptive eligibility qualified entity should not be disqualified for failing to meet performance standards and shall contain any documentation the presumptive eligibility qualified entity wishes the director to consider. It is entirely within the discretion of the department director whether to reconsider the disqualification decision.

3. Disqualification shall be for a minimum of a three- (3-) year period. At the conclusion of the disqualification period, the presumptive eligibility qualified entity may reapply and shall successfully complete training required by the department director in order to be reinstated.

(8) Applicants and participants may not appeal the presumptive eligibility determination made by a presumptive eligibility qualified entity under this rule. However, nothing in this rule limits the ability of an applicant or participant to appeal the final determination of eligibility for MO HealthNet benefits made by the division as otherwise provided by law.

(9) Upon the effective date of this rule, any existing agreements regarding presumptive eligibility between the division and MO HealthNet providers, including providers designated as "qualified providers" or "qualified entities" in such agreements, shall terminate and shall be superseded by this rule, except as follows:

(A) Any provider that is party to such an agreement that notifies the division within thirty (30) days of the effective date of this rule that it intends to continue as a presumptive eligibility qualified entity will not be required to be approved as a presumptive eligibility qualified entity under subsection (3)(B) of this rule with respect to the MO HealthNet program for which it was previously authorized by contract to make presumptive eligibility determinations;

(B) Any provider who notifies the division under subsection (9)(A) of its intention to continue as a presumptive eligibility qualified entity shall remain subject to all other requirements of this rule, including the requirement to submit the information specified in subsection (3)(A).

AUTHORITY: section 207.022, RSMo Supp. 2014, section 208.151.1(22), RSMo Supp. 2013, and section 660.017, RSMo 2000. Original rule filed March 31, 2016, effective Sept. 30, 2016.*

**Original authority: 207.022, RSMo 2014; 208.151, RSMo 1967, amended 1973, 1981, 1982, 1987, 1988, 1989, 1990, 1991, 1993, 1995, 2001, 2005, 2007, 2011, 2013; and 660.017, RSMo 1993, amended 1995.*

13 CSR 40-7.060 Show-Me Healthy Babies Program

PURPOSE: This rule establishes the eligibility requirements for the Show-Me Healthy Babies Program, in accordance with section 208.662, RSMo.

(1) Scope. This rule describes the eligibility requirements and coverage for the Show-Me Healthy Babies Program.

(2) For purposes of this section, the following definitions shall apply:

(A) "Affordable insurance" or "affordable health care coverage" shall mean a health insurance plan (employer-sponsored or otherwise) that covers the pregnancy and that requires monthly premiums equal to the amounts described in section 208.640, RSMo and section 1397cc(e)(3)(B) of Title 42, *United States Code*;

(B) "Household" shall have the same definition that appears in 13 CSR 40-7.020;

(C) "Modified adjusted gross income (MAGI)" shall mean income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B), *Internal Revenue Code*, pursuant to the rules and exceptions in 13 CSR 40-7.030;

(D) "Participant" shall mean any individual who has applied for, or is receiving, or has been denied, income maintenance benefits or services through an income maintenance program administered by the Family Support Division (hereinafter, "division"), including an unborn child;

(E) "Post-partum" shall mean healthcare coverage continues until the last day of the month containing the sixtieth day after the termination of pregnancy; and

(F) "Program" shall mean the Show-Me Healthy Babies program, unless described otherwise.

(3) To be eligible for the program, a participant—

(A) Must be the unborn child of a pregnant woman. The pregnancy is verified upon the mother's (or her representative's) attestation that she is pregnant. The division may request more verification if information is not reasonably compatible with the participant's attestation in accordance with section 457.380(e) of Title 42, *Code of Federal Regulations*;

(B) Must not be eligible for any other non-Children's Health Insurance Program (CHIP), MO HealthNet program that covers the pregnancy and does not require a premium or a spend-down in exchange for coverage; and

(C) Must not have insurance that covers the same pregnancy-related services as this program;

(D) If not insured, does not have access to affordable insurance that covers the same pregnancy-related services as this program; and

(E) Must be in a household with a modified adjusted gross income no greater than three hundred percent (300%) of the federal poverty level, subject to the rules and exceptions in 13 CSR 40-7.030 and the verification requirements in 13 CSR 40-7.040.

(4) Coverage.

(A) This program provides to unborn children and their mothers the same coverage afforded to pregnant women under section 1397ll(d)(1) of Title 42, *United States Code*. This coverage includes, but is not limited to—

1. Coverage effective no earlier than the month of conception;

2. Post-partum coverage for the mother that continues through the end of the month, in which the sixtieth day after the termination of pregnancy occurs, provided the mother applied for services in the program while pregnant with the child.

(B) Participants in this program are not eligible for automatic, extended women's health services pursuant to 13 CSR 70-4.090.

(C) Children born to participants covered under this program are eligible for continuing coverage for one (1) year after the birth, under the applicable CHIP level of care. During this period, no premium shall be applied, regardless of the level of care.

(D) There is no waiting period for participants to receive coverage once they are determined eligible for the program, regardless of the household's level of income.

AUTHORITY: sections 207.022 and 208.662, RSMo Supp. 2014. Original rule filed Dec. 23, 2015, effective June 30, 2016.*

**Original authority: 207.022, RSMo 2014 and 208.662, RSMo 2014.*