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**Rules of**  
**Department of Social Services**  
**Division 70—Division of Medical Services**  
**Chapter 4—Conditions of Recipient Participation,**  
**Rights and Responsibilities**

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**Title 13—DEPARTMENT OF  
SOCIAL SERVICES**

**Division 70—Division of Medical  
Services**

**Chapter 4—Conditions of Recipient  
Participation, Rights and  
Responsibilities**

**13 CSR 70-4.030 Recipient Liability for  
Medical Services Not Reimbursable to the  
Provider by the Medicaid Agency**

*PURPOSE: This rule establishes the guidelines for determination of recipient liability for medical services not reimbursable to the provider by the Medicaid agency.*

(1) When an enrolled Medicaid provider provides an item or service to a Medicaid recipient eligible for the item or service on the date provided, there shall be a presumption that the provider accepts the recipient's Medicaid benefits and seeks reimbursement from the Medicaid agency in accordance with all of the applicable Medicaid rules. This presumption shall be overcome only by written evidence of an agreement between the provider and the recipient indicating that Medicaid is not the intended payor for the specific item or service but rather that the recipient accepts the status and liabilities of a private pay patient. All third-party resource benefits must be exhausted before payment will be made by the division for the item or service rendered to that recipient. For purposes of this rule, neither the provider nor the recipient shall be required to exhaust all third-party resources in those situations where the provider or recipient elect not to pursue contingent liability from a third-party tortfeasor. Both the provider and the recipient have an affirmative duty to report the existence of contingent liability to the Division of Medical Services and the recipient has the duty to cooperate with the Division of Medical Services if the division elects to pursue the contingent liability.

(2) When an item or service is rendered to a Medicaid recipient who was eligible for the item or service on the date provided and provision of the item or service is billed to the Medicaid agency by an enrolled Medicaid provider who is not reimbursed by the agency for the item or service claimed, the item or service will not be the liability of the recipient if the item or service would have been otherwise payable by the Medicaid agency at the Medicaid allowable amount had the provider followed all of the policies, procedures and rules applicable to the item or service as of the date provided. If the item or

service is not otherwise payable for reasons unrelated to the actions of the provider, the recipient is liable to the provider for payment of the item or service.

(3) The creation of a presumptive acceptance by a provider of the Medicaid benefits for a Medicaid covered service and the requirement for written evidence of an agreement to overcome presumptive acceptance, as established in this rule, shall not be applicable to services provided to a recipient who is dually eligible and entitled to both Medicaid and Medicare Part B medical insurance benefits.

(4) The provisions of this rule shall apply to items or services provided on or after July 11, 1985.

*AUTHORITY: sections 207.020, 208.152 and 208.153, RSMo 1986. \* This rule was previously filed as 13 CSR 40-81.140. Original rule filed April 16, 1985, effective July 11, 1985. Amended: Filed March 2, 1988, effective May 12, 1988.*

*\*Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986; 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978(2), 1981, 1986, 1988, 1990; and 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991.*

**13 CSR 70-4.040 Eligibility Corrective  
Action Recipient Payments**

*PURPOSE: This rule establishes the basis on which recipients may be reimbursed by the Medicaid program for Title XIX services and for services covered under state-only types of assistance programs and after this referred to as Medicaid paid by them to providers between the date of the initial agency decision denying their eligibility and the date of the agency or court decision establishing their eligibility for Medicaid.*

(1) All recipients whose eligibility for Medicaid benefits is denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision or any other final agency decision rendered on or after January 1, 1986 may be reimbursed by the Medicaid agency for Medicaid services paid by the recipients to providers between the date of the agency decision denying their eligibility and the date of the agency or court decision establishing their eligibility for Medicaid benefits.

(A) Payments to a recipient will be made only for medical services which were covered services at the time provided in accordance with Medicaid program benefits, limitations

and requirements applicable to the services or the recipient as of the date provided, except that prior authorization requirements will not apply.

(B) Payments may be made for services of either an enrolled Medicaid provider or for providers who do not participate in Medicaid.

(C) Payments to a recipient will be limited to the lesser of the Medicaid allowable amount for the covered item or service as of the date provided or the aggregate amount paid by the recipient for the covered item or service.

(D) Any medical expenses paid by the recipient which are for the purpose of meeting that recipient's spenddown obligation are not payable.

(E) All third-party resource benefits received by the recipient for Medicaid-covered services must be applied against the lesser of the Medicaid allowable amount for the covered item or service as of the date provided or the aggregate amount paid by the recipient for the covered item or service. No payment shall be made to the recipient until all third-party resource benefits have been exhausted as would have been applicable to recipients receiving Medicaid. For purposes of this rule, neither the provider nor the recipient shall be required to exhaust all third-party resources in those situations where the provider or the recipient elects not to pursue contingent liability from a third-party tortfeasor. Both the provider and the recipient have an affirmative duty to report the existence of contingent liability to the Division of Medical Services and the recipient has the duty to cooperate with the Division of Medical Services if the division elects to pursue the contingent liability.

(F) As evidenced by the Medicaid agency's date of receipt, the recipient or person legally responsible will have one (1) year from the date of the final agency or court decision establishing eligibility to submit all written requests for recipient payment to the Medicaid agency with sufficient documentation to determine the appropriate reimbursement amount under the applicable provisions of subsections (1)(A), (C) and (E) for the Medicaid-covered items or services paid by the recipient.

*AUTHORITY: sections 208.153 and 208.201, RSMo 2000. \* This rule was previously filed as 13 CSR 40-81.141. Original rule filed April 16, 1985, effective Jan. 1, 1986. Amended: Filed Jan. 22, 1992, effective Sept. 6, 1992. Amended: Filed May 1, 2003, effective Nov. 30, 2003.*



\*Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991 and 208.201, RSMo 1987.

13 CSR 70-4.050 Copayment and Coinsurance for Certain Medicaid-Covered Services

PURPOSE: This rule implements recipient copayment for certain Missouri Medicaid program areas.

(1) Recipients eligible to receive Missouri Medicaid services under certain program areas shall be required to pay a small portion of the costs of the services. The services to be affected by the copayment or coinsurance requirements are—

(A) All audiological services and hearing aids provided through the Audiology Program;

(B) All dental services and dentures provided through the Dental Program;

(C) All optometric services, eyeglasses and artificial eyes provided through the Optical Program;

(D) All podiatry services provided through the Podiatry Program;

(E) Inpatient hospital services;

(F) Outpatient hospital clinic/emergency room services; and

(G) Physician services rendered in a hospital outpatient clinic or emergency room.

(2) Participating providers of services in the program areas named shall be required to charge copayment or coinsurance, as applicable, on each subject item of service performed or furnished, or on each date of service as applicable.

(3) Copayment charged shall be in accordance with 42 CFR 447.54 and, applicable to the services described in subsections (1)(A), (B) (excepting dentures), (C) and (D), based on the following schedule:

Table with 2 columns: Medicaid Payment for Each Item of Service, Recipient Copayment Amount. Rows include \$10.99 or less, \$11.00-\$25.99, \$26.00-\$50.99, \$51.00 or more.

(4) Under this rule, coinsurance shall apply only to Medicaid-covered full and partial dentures. The coinsurance amount to be charged shall be five percent (5%) of the lesser of the Medicaid maximum allowable

amount for the service or the provider's billed charge.

(5) Copayment to be charged for inpatient hospital services shall be ten dollars (\$10) per hospitalization, applicable to the first day of the Medicaid-covered hospital stay and to be charged to the recipient prior to discharge.

(6) Co-payment to be charged for hospital outpatient clinic or emergency room services shall be two dollars (\$2) for each date of service on which the recipient receives, either one (1) or both, outpatient clinic or emergency room services.

(7) Co-payment to be charged for physician services provided in a hospital outpatient clinic or emergency room shall be one dollar (\$1) for each date of service on which the recipient receives these services.

(8) With noted exceptions, the following exemptions to the copayment requirement apply to the services described in subsections (1)(A)–(G):

(A) Services provided on or after December 1, 1984 to recipients under eighteen (18) years of age;

(B) Services to recipients residing within a skilled nursing home, an intermediate care nursing home, a residential care home, an adult boarding home or a psychiatric hospital;

(C) Services to recipients who have both Medicare and Medicaid entitlement if Medicare covers the service and provides payment for it;

(D) Emergency or transfer inpatient hospital admissions;

(E) Emergency services provided in an outpatient clinic or emergency room, such as—heart attack, hemorrhaging, poisoning, concussion, bone fractures or stroke;

(F) Certain therapy services (physical therapy, chemotherapy, radiation therapy, psychotherapy and chronic renal dialysis) except when provided as an inpatient hospital service;

(G) Family planning services;

(H) Services provided to pregnant women which are directly related to the pregnancy or a complication of the pregnancy;

(I) Services provided to foster care recipients; and

(J) Early Periodic Screening, Diagnosis and Treatment services.

(9) Providers of services as described in this rule and as subject to a copayment or coinsurance requirement may not deny or reduce services otherwise eligible for Medicaid benefits on the basis of the recipient's inability to

pay the due copayment or coinsurance amount when charged.

(10) A recipient's inability to pay a required coinsurance or copayment amount, as due and charged when a service is delivered, in no way shall extinguish the recipient liability to pay the due amount.

(11) Participation privileges in the Medicaid program shall be limited to providers who accept, as payment in full, the amounts paid by the state agency plus any coinsurance or copayment amount required of the recipient.

(12) Providers of services in the program areas named must charge copayment or coinsurance as specified at the time the service is provided to retain their participation privileges in the Missouri Medicaid program.

(13) Providers must maintain records of copayment or coinsurance amounts for five (5) years and must make those records available to the Department of Social Services upon request.

AUTHORITY: section 207.020, RSMo 1986. This rule was previously filed as 13 CSR 40-81.054. Emergency rule filed Oct. 21, 1981, effective Nov. 1, 1981, expired Feb. 10, 1982. Original rule filed Oct. 21, 1981, effective Feb. 11, 1982. Emergency amendment filed Jan. 21, 1983, effective Feb. 1, 1983, expired May 11, 1983. Amended: Filed Jan. 21, 1983, effective May 12, 1983. Amended: Filed Aug. 14, 1984, effective Nov. 11, 1984.

13 CSR 70-4.051 Copayment for Pharmacy Services

PURPOSE: This rule establishes the regulatory basis for the Medicaid requirement of eligible recipient copayment when receiving covered pharmacy services.

(1) All Medicaid-eligible recipients shall be responsible for a copayment upon receipt of each original or refilled prescription of a Medicaid-covered drug unless the service is exempted under provisions of section (2). Copayment responsibility and amounts collectible shall be as follows:

Table with 2 columns: Medicaid Maximum Allowable Amount for Each Item of Service, Recipient Copayment Amount. Rows include \$10.00 or less, \$10.01-\$25.00, \$25.01 or more.



The Medicaid maximum allowable amount for each item of service is the lesser of the providers billed charge or the price(s) in the drug pricing file 13 CSR 70-20.070(3).

(2) Services exempted from the copayment requirement for drugs are—

(A) Services to recipients under nineteen (19) years of age;

(B) Services to recipients residing within a skilled nursing home, an intermediate care nursing home, a residential care home, an adult boarding home or a psychiatric hospital;

(C) Those drugs specifically identified as relating to family planning services (oral contraceptives);

(D) Those drugs which are prescribed and identified as relating to an Early Periodic Screening, Diagnosis and Treatment (EPSDT) program screening or referral service; and

(E) Those drugs prescribed for foster care children.

(3) Those drugs which are exempt from the requirement of copayment as related to an EPSDT screening or referral service must be confirmed as such to the dispenser through one (1) of the following methods:

(A) The prescribing physician (MD, DO, dentist, podiatrist) identifies on the prescription that it relates to EPSDT examination and treatment; or

(B) The prescribing physician verbally states that the prescription relates to EPSDT examination and treatment in cases of telephone prescribing. This verbal assertion must be included in the dispensing provider's reduction into writing of the prescription.

(4) Providers of service may not deny or reduce services otherwise eligible for Medicaid benefits on the basis of the recipient's inability to pay the due copayment amount when charged.

(5) A recipient's inability to pay a required copayment amount, as due and charged when a service is delivered, shall in no way extinguish the recipient liability to pay the due amount.

(6) Providers of service must collect copayment as specified in accordance with section 208.152, RSMo. Participation privileges in the Medicaid program shall be limited to providers who accept, as payment in full, the amounts paid by the state agency plus any copayment amount required of the recipient and collected or collectible as charged by the provider.

(7) Providers must maintain records of copayment amounts for five (5) years and must make these records available to the Department of Social Services upon request.

(8) The computation and application of the required copayment as it applies to all nonexempted Medicaid-covered drug prescriptions shall be performed by the provider dispensing the covered Medicaid drug. No alterations or changes are to be made to claims by providers which reflect the collection or application of the required copayment amount.

*AUTHORITY: sections 208.152, 208.153 and 208.201, RSMo 1994. \* This rule was previously filed as 13 CSR 40-81.055. Original rule filed April 14, 1982, effective July 11, 1982. Amended: Filed Oct. 13, 1983, effective Jan. 13, 1984. Amended: Filed May 15, 2000, effective Nov. 30, 2000.*

*\*Original authority: 208.152 RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; and 208.201, RSMo 1987.*

### 13 CSR 70-4.060 Required Reporting of Injuries Received by Title XIX Recipients

*PURPOSE: The Division of Family Services has statutory responsibility under House Bill 1086, 208.215.8. to require that recipients of benefits as defined in Chapter 208, RSMo report injuries to the Division of Family Services.*

(1) All recipients of benefits provided for in Chapter 208, RSMo, within thirty (30) days of the date of benefit receipt, shall provide the county office in the county of their residence with detailed information concerning any occurrences, other than an illness, routine medical service or other medical treatment not related to a casualty, where medical treatment is given as a result of a casualty.

(2) Casualty as used in this regulation means an accident, event due to sudden unusual occurrence, misfortune or mishap.

(3) Recipient is defined as any person for whom medical benefits are provided for in Chapter 208, RSMo.

(4) Failure to supply the information on a form prescribed by the Medical Services Division within thirty (30) days of the occurrence, as determined by the Division of Family Services, may be held as constituting recipient failure to cooperate and result in loss of benefits.

(5) Loss of benefits resulting from a determination of recipient failure to cooperate in accordance with the provisions of this rule shall not penalize nor deny reimbursement to a Title XIX provider who provided covered services to a recipient presenting valid evidence of Title XIX eligibility as of the date service is provided, where the provider has advised the Division of Family Services that the covered services rendered may have resulted from circumstances defined in this rule by completing the accident portion of the claim form or other written notice.

*AUTHORITY: sections 207.020, 208.153 and 208.159, RSMo 1986. \* This rule was previously filed as 13 CSR 40-81.092. Original rule filed Aug. 13, 1982, effective Nov. 11, 1982.*

*\*Original authority: 207.020 RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; and 208.159, RSMo 1979.*

### 13 CSR 70-4.070 Title XIX Recipient Lock-In Program

*PURPOSE: This rule establishes the regulatory basis for implementation of a method to limit or restrict the use of the recipient's Medicaid identification card to designated providers of medical services.*

(1) Definitions which shall apply in the administration of this program.

(A) Misutilization of medical services is defined as the act of seeking or obtaining medical services, or both, from a number of like providers and in quantities which exceed the levels that are considered medically necessary by current medical practices, standards and policies of the Missouri Title XIX Medicaid Program.

(B) Lock-in is defined as the method to limit or restrict the use of the recipient's Medicaid identification (ID) card to a designated provider(s) only. When one (1) of the designated providers is a physician, this provider is the primary-care physician and is responsible for providing or directing, or both, the recipient's medical care and for making any necessary referrals to other providers as medically indicated.

(C) The Division of Medical Services, Surveillance and Utilization Review System Unit will review all suspect or potential cases of lock-in. The Surveillance and Utilization Review System Unit professional staff will initiate lock-in procedures after utilization



review of documented services indicate misutilization of Title XIX services, benefits, or both.

(2) The lock-in or limitation is for one (1) person and the fiscal agent audit is for that person's individual Medicaid ID number. Payment to any other provider(s) with the provider type of the designated provider is limited to—

(A) Documented emergencies; and

(B) Referral from the designated provider, with designated provider's name or provider's number on all claims submitted by the other provider(s) to show designated provider as the referring physician or provider.

(3) In cases where treatment or service by another provider of the same type as the designated provider is needed is not an emergency and the designated provider is not available to render service to the recipient, the recipient may obtain an authorization from the individual's Division of Family Services local office which allows the recipient to obtain the needed service from a different provider. The form is titled Medical Referral Form of Restricted Recipient and is numbered MSS-S/UR-118. This form is also available from the state office Division of Medical Services, Surveillance and Utilization Review System Unit, P.O. Box 6500, Jefferson City, MO 65102-6500. The form must be attached to the different provider's claim for reimbursement.

(4) Change of the designated provider may be requested by the recipient during a period of lock-in. The recipient must contact his/her Division of Family Services local office and request the change of provider by completing the Recipient Lock-In Form Authorization for Medical Services. The change of approved authorized provider(s) will be effective the first day of the month following the receipt of the completed Authorization for Medical Services Form. In the event the change of authorized provider(s) cannot be reflected on the recipient's Medicaid ID card on the first day of the month following the receipt of the Authorization for Medical Services Form, the recipient's Division of Family Services local office may replace the Medicaid ID card with a corrected income maintenance letter of eligibility showing the proper listing of designated provider. A copy of the income maintenance letter must be forwarded to the Division of Medical Services Surveillance and Utilization Review System Unit for case documentation. No more than one (1) provider-type change may be allowed in a

three (3)-month period. Exceptions to the previously mentioned may be approved if documentation is presented for just cause of additional authorized provider changes within the three (3)-month period. This documentation must be submitted by the recipient's caseworker in writing for review and approval by the Division of Medical Services Surveillance and Utilization Review System Unit professional staff.

(5) Lock-In Provider Types.

(A) Medical—physician.

(B) Pharmacy.

(C) Dental.

(D) Optometrist.

(E) Optical company.

(F) Ambulance.

(G) Durable medical equipment.

(H) Institutional—inpatient—outpatient—emergency room facility.

(I) Audiology.

(J) Home health.

(K) Podiatry.

(L) Independent clinic

(6) Recipients have free choice of providers who are participants in the Missouri Medicaid program. Professional practitioners have the right to accept or refuse recipients for treatment. Both the provider and recipient must be agreeable to the lock-in relationship. If the recipient does not cooperate in designating a lock-in provider, the Division of Medical Services or local Division of Family Services office may arrange for a provider after documenting the recipient's lack of cooperation in designating a provider. The medical ID card may be held only as a mechanism to get the recipient to the Division of Family Services office to discuss or select a lock-in provider.

(7) The recipient selected for lock-in has the right to the fair hearing procedures as offered under applicable state law and federal regulations.

(8) The lock-in period will be for a minimum of twelve (12) months and a maximum of twenty-four (24) months. Not sooner than twelve (12) months but no longer than twenty-four (24) months after a recipient has been placed on lock-in, the Surveillance and Utilization Review System Unit professional staff will review the case and continue the recipient on lock-in if review of documented services indicates continuing misutilization of Title XIX services, benefits, or both. The lock-in period will again be for a minimum of twelve (12) months and a maximum of twenty-four (24) months before another review is conducted, after which lock-in may again be

renewed. Recipients who have initially been placed on the lock-in program prior to December 1, 1985 will continue to be subject to twelve (12)-month reviews. The recipient has the right to the fair hearing procedures as offered under applicable state law and federal regulations if s/he is continued on lock-in after a review. The effective date for the start of lock-in should be the same for the medical ID card and the audit implementation of the fiscal agency by the Surveillance and Utilization Review System Unit. A form processed by electronic data processing and forwarded to the fiscal agency will give the effective date of lock-in. If a case is closed during a twelve (12)-month period, the lock-in restriction would automatically still be in effect at the fiscal agent unless the medical ID number was changed. The lock-in period should be continued a full twelve (12) months. A new Authorization of Medical Services Form should be submitted on any change of provider. The Surveillance and Utilization Review System Unit should also be advised of any name or Medicaid ID number changes instigated in behalf of lock-in recipients.

(9) If Missouri Medicaid recipients are identified as misutilizing the Title XIX Medicaid Program in the following areas, but not limited to, lock-in proceedings, referral to the Division of Investigation, or both, will be implemented:

(A) Lending Medicaid ID card to noneligible persons;

(B) Submitting forged documents to providers for medical benefits or services;

(C) Seeking excessive or unnecessary medical care as defined in subsection (1)(A) of this rule, that is, drugs, office visits, eyeglasses, dentures, etc.;

(D) Utilizing multiple medical providers; or

(E) Refusing to submit to or failing to have predicted urine or blood levels following testing for opioid or opioid-like controlled substances covered by Missouri Medicaid while engaged in a pain or substance abuse treatment regimen.

*AUTHORITY: section 208.201, RSMo 2000.\* This rule was previously filed as 13 CSR 40-81.200. Emergency rule filed July 13, 1981, effective Aug. 1, 1981, expired Oct. 10, 1981. Original rule filed July 13, 1981, effective Oct. 11, 1981. Amended: Filed Sept. 4, 1985, effective Dec. 1, 1985. Amended: Filed Nov. 2, 1988, effective Jan. 13, 1989. Amended: Filed Aug. 1, 2003, effective Feb. 29, 2004.*

*\*Original authority: 208.201, RSMo 1987.*



### 13 CSR 70-4.080 Children's Health Insurance Program

*PURPOSE: This rule establishes components of the Children's Health Insurance Program which will provide health care coverage to uninsured, low income children pursuant to Senate Bill 632 enacted by the 89th General Assembly, 1998.*

#### (1) Definitions.

(A) Available income. For the purpose of this rule available income shall be defined as the household's total gross income compared to one hundred eighty-five percent (185%), two hundred twenty-five percent (225%) and three hundred percent (300%) of the federal poverty level for the household size.

(B) Cost sharing. Payment of co-payments and premiums.

(C) Children. Persons up to nineteen (19) years of age.

(D) Health insurance. Any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provision of health care benefits. The term "health insurance" does not include short-term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) An uninsured child/children shall not have had health insurance for six (6) months prior to the month of application pursuant to 208.185, RSMo.

(3) If a child/children had health insurance and such health insurance coverage was dropped, within six (6) months prior to the month of application, the child is not eligible for coverage under this rule until six (6) months after coverage was dropped.

(4) The six (6)-month period of ineligibility would not apply to children who lose health insurance due to—

(A) A parent's or guardian's loss of employment due to factors other than voluntary termination;

(B) A parent's or guardian's employment with a new employer that does not provide an option for dependent coverage;

(C) Expiration of a parent's or guardian's dependent Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage period;

(D) Lapse of a child's (children's) health insurance when maintained by an individual other than custodial parent or guardian; or

(E) Lapse of a child's (children's) health insurance when the lifetime maximum benefits under their private health insurance have been exhausted.

(5) Parent(s) and guardian(s) of uninsured children with available income above two hundred twenty-five percent (225%) and below three hundred percent (300%) of the federal poverty level must certify, as a part of the application process, that the child does not have access to affordable employer-sponsored health insurance or other affordable health insurance available to the parent(s) or guardian(s) through their association with an identifiable group (for example, a trade association, union, professional organization) or through the purchase of individual health insurance coverage.

(A) Affordable access is calculated by comparing the health insurance monthly dependent premium to one hundred thirty-three percent (133%) of the monthly statewide weighted average child/children premium required by the Missouri Consolidated Health Care Plan. Adjustment to the monthly statewide weighted average, based on changes in the Missouri Consolidated Health Care Plan, shall be calculated yearly in March with an effective date of July 1 of the same calendar year.

(B) Health insurance premiums less than or equal to one hundred thirty-three percent (133%) of the monthly average dependent premium required by the Missouri Consolidated Health Care Plan are deemed affordable and shall result in ineligibility for the child/children.

(6) An uninsured child/children with available income less than two hundred twenty-six percent (226%) of the federal poverty level shall be eligible for service(s) from the date the application is received. No service(s) will be covered prior to the date the application is received or September 1, 1998, whichever is later.

(7) An uninsured child/children with available income above two hundred twenty-five percent (225%) and below three hundred percent (300%) of the federal poverty level shall

be eligible for service(s) thirty (30) calendar days after the application is received if the required premium has been received.

(A) Parent(s) or guardian(s) of uninsured children with available income above two hundred twenty-five percent (225%) and below three hundred percent (300%) of the federal poverty level are responsible for a monthly premium equal to the statewide weighted average child/children premium required by the Missouri Consolidated Health Care Plan.

(B) The premium must be paid prior to service delivery.

(C) The premium notice shall include information on what to do if there is a change in available income.

(D) No service(s) will be covered prior to the effective date which is thirty (30) calendar days after the date the application is received.

(8) If the parent or guardian discontinues payment of premiums, a past due notice shall be sent requesting remittance within twenty (20) calendar days from date of the letter. Failure to make payment shall result in the child's ineligibility for coverage for the following six (6) months.

(9) Premium adjustments, based on changes in the Missouri Consolidated Health Care Plan, shall be calculated yearly in March with an effective date of July 1 of the same calendar year. Individuals shall be notified of the change in premium amount at least thirty (30) days prior to the effective date.

(10) The six (6)-month waiting period and thirty (30)-calendar-day delay in service delivery is not applicable to a child/children already participating in the program when the parent's or guardian's income changes. Coverage shall be extended for thirty (30) calendar days to allow for premium collection and to ensure continuity in coverage. Eligibility shall be discontinued for the child/children if the premium payment is not made within the thirty (30)-day extension.

(11) Parent(s) or guardian(s) of uninsured children with available income above two hundred twenty-five percent (225%) and below three hundred percent (300%) of the federal poverty level are responsible for a co-payment at the time of professional service and for prescriptions.

(A) The co-payment is equal to the co-payment required by the Missouri Consolidated Health Care Plan.

(B) Co-payment adjustments, based on changes in the Missouri Consolidated Health



Care Plan, shall be calculated yearly in March with an effective date of July 1 of the same calendar year.

(C) Individuals shall be notified of change(s) in the co-payment amount(s) at least thirty (30) days prior to the effective date.

(D) Providers may require payment of the co-payment prior to service delivery and service may be denied for failure to make co-payment. No co-payments shall be required for well-baby and well-child care including age-appropriate immunizations.

(12) Parent(s) or guardian(s) of uninsured children with income above one hundred eighty-five percent (185%) and at or below two hundred twenty-five percent (225%) of the federal poverty level for the household size are responsible for a five-dollar (\$5) co-payment at the time of professional service. Providers may require payment of the co-payment prior to service delivery and may deny services for failure to make co-payment. No co-payments shall be required for well-baby and well-child care including age-appropriate immunizations.

(13) The total aggregate cost-sharing for a family covered by this rule shall not exceed five percent (5%) of the family's available income for a twelve (12)-month period of coverage beginning with the first month of service eligibility. Families responsible for cost-sharing shall be notified of their maximum liability for the twelve (12)-month period following service eligibility. When the total aggregate cost-sharing has reached five percent (5%) of the family's available income all co-payments and premiums shall be waived for the remainder of the twelve (12)-month period. Waiver in cost-sharing shall be made upon notification and documentation of co-payments from the family that payments have been made up to five percent (5%) of their yearly available income.

(14) Parents of uninsured children must certify that their total net worth does not exceed two hundred fifty thousand dollars (\$250,000) to be eligible for health insurance under this rule.

(15) For the purposes of this rule, children participating in the Missouri Health Insurance Pool and child/children whose annual maximum benefits on a particular medical service under their private insurance have been exhausted are considered insured. Child/children whose parent(s) or guardian(s) drop Missouri Health Insurance Pool coverage in order to qualify under this rule shall

not be eligible for six (6) months from the month coverage was terminated.

*AUTHORITY: sections 208.631, 208.633, 208.636, 208.640, 208.643, 208.646, 208.650, 208.655, 208.657 and 208.660, RSMo Supp. 1998 and 208.201, RSMo 1994.\* Original rule filed July 15, 1998, effective Feb. 28, 1999.*

*\*Original authority: 208.201, RSMo 1987; 208.631, RSMo 1998; 208.633, RSMo 1998; 208.636, RSMo 1998; 208.640, RSMo 1998; 208.643, RSMo 1998; 208.646, RSMo 1998; 208.650, RSMo 1998; 208.655, RSMo 1998; 208.657, RSMo 1998; and 208.660, RSMo 1998.*

**13 CSR 70-4.090 Uninsured Parents' Health Insurance Program**

*PURPOSE: This rule establishes the Uninsured Working Parents' Health Insurance Program. This program will provide payment for health care coverage for uninsured, low income, working parents leaving welfare for work thereby reducing future dependence on welfare and reducing the possibility of a family's future dependence on welfare as authorized pursuant to section 208.040, RSMo. The program is also authorized pursuant to the award of the Missouri State Medicaid Section 1115 Health Care Reform Demonstration Proposal approved by the Health Care Financing Administration.*

(1) Definitions.

(A) Health insurance. Any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provision of health care benefits. The term "health insurance" does not include short-term, accident, fixed indemnity, limited benefit or credit insurance coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(B) Co-payment. A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as ten dollars (\$10) for a professional service.

(C) Parents. For purposes of this regulation the term parents refers to biological or adoptive parent(s).

(2) The following uninsured individuals shall be eligible to receive medical services to the extent and in the manner provided in this regulation:

(A) Individuals losing transitional medical assistance (TMA) who would not otherwise be insured or Medicaid eligible, with net income at or below one hundred percent (100%) of the federal poverty level for the household size—

1. Eligibility for the Uninsured Parents' Health Insurance Program for individuals losing TMA ends twelve (12) months after TMA eligibility ends; and

2. After coverage ends, the individuals with a child eligible for MC+ have the option of staying in the MC+ health plan, where managed care is available, if the parents pay the cost of the state's cost for the time period covered by the Missouri Medicaid Section 1115 Health Care Reform Demonstration Proposal as approved by the Health Care Financing Administration;

(B) Uninsured women who do not qualify for other medical assistance benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage, will continue to be eligible for family planning and limited testing of sexually transmitted diseases (EWH), regardless of income, for twelve (12) consecutive months.

(3) Beneficiaries covered in section (2) of this rule shall be eligible for service(s) from the date their application is received. No service(s) will be covered prior to the date the application is received.

(4) The following services are covered for beneficiaries of the Uninsured Parents' Health Insurance Program if they are medically necessary:

- (A) Inpatient hospital services;
- (B) Outpatient hospital services;
- (C) Emergency room services;
- (D) Ambulatory surgical center, birthing center;

(E) Physician, advanced practice nurse, and certified nurse midwife services;

(F) Maternity benefits for inpatient hospital and certified nurse midwife. The health plan shall provide coverage for a minimum of forty-eight (48) hours of inpatient hospital services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care under the provision of Chapter 197, RSMo. A shorter length of hospital stay for services related to



maternity and newborn care may be authorized if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law. The health plan is to provide coverage for post-discharge care to the mother and her newborn. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization and be documented in the patient's medical record. The first post-discharge visit shall occur within twenty-four (24) to forty-eight (48) hours. Post-discharge care shall consist of a minimum of two (2) visits at least one (1) of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physician assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. If the health plan intends to use another nationally recognized medical organization's guidelines, the state agency must approve prior to implementation of its use;

(G) Family planning services;

(H) Pharmacy benefits;

(I) Dental services to treat trauma;

(J) Laboratory, radiology and other diagnostic services;

(K) Prenatal case management;

(L) Hearing aids and related services;

(M) Eye exams and services to treat trauma or disease (one (1) pair of glasses after cataract surgery only);

(N) Home health services;

(O) Emergent (ground or air) transportation;

(P) Non-emergent transportation only for members in ME Code 78 Parents' Fair Share;

(Q) Mental health and substance abuse services;

(R) Services of other providers when referred by the health plan's primary care provider;

(S) Hospice services;

(T) Durable medical equipment (including but not limited to: orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs and walkers, diabetes supplies and equipment);

(U) Diabetes self-management training for persons with gestational, Type I or Type II diabetes;

(V) Services provided by local health agencies (may be provided by the health plan or through an arrangement between the local health agency and the health plan)—

1. Screening, diagnosis, and treatment of sexually transmitted diseases;

2. HIV screening and diagnostic services;

3. Screening, diagnosis, and treatment of tuberculosis; and

(W) Emergency medical services. Emergency medical services are defined as those health care items and services furnished or required to evaluate or stabilize a sudden and unforeseen situation or occurrence or a sudden onset of a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably be expected by a prudent lay person, possessing average knowledge of health and medicine, to result in:

1. Placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part; or

4. Serious harm to a member or others due to an alcohol or drug abuse emergency; or

5. Injury to self or bodily harm to others; or

6. With respect to a pregnant woman who is having contractions: a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(5) Individuals losing TMA shall owe a ten dollar (\$10) co-payment for certain profes-

sional services and a five dollar (\$5) co-payment in addition to the recipient portion of the professional dispensing fee for pharmacy services required by 13 CSR 70-4.051.

(A) Providers may request payment of the mandatory co-payment(s) prior to or after service delivery.

(B) The co-payment amount shall be deducted from the Medicaid maximum allowable amount for fee-for-service claims reimbursed by the Division of Medical Services.

(C) Service(s) may not be denied for failure to pay the mandatory co-payment(s).

(D) When a mandatory co-payment is not paid, the Medicaid provider will have the following options:

1. Forego the co-payment entirely;

2. Make arrangements for future payment with the recipient; or

3. File a claim with the Division of Medical Services to report the non-payment of the mandatory co-payment(s) and secure payment for the service from the Division of Medical Services.

(E) When the Division of Medical Services receives a claim from a Medicaid fee-for-service provider for non-payment of the mandatory co-payment, the division shall send a notice to the recipient—

1. Requesting that the recipient reimburse the Division of Medical Services for the mandatory co-payment made on their behalf;

2. Requesting information from the recipient to determine if the mandatory co-payment was not made because there has been a change in the financial situation of the family; and

3. Advising the recipient of the possible loss of coverage for up to six (6) months if the recipient fails to pay three (3) co-payments in one (1) year.

(F) The recipient will be allowed fourteen (14) calendar days to respond. If the recipient indicated there has been a change in the financial situation of the family, the state shall redetermine eligibility—

1. If the eligibility redetermination places the recipient in a non-mandatory co-payment category, there will be no co-payment due; or

2. If the eligibility redetermination does not place the recipient in a non-mandatory co-payment category another notice will be sent to the recipient about the mandatory co-payment provision of the program which shall include the number of co-payments that have not been paid and how many may not be paid before a recipient is terminated from the program.

(G) Notice of non-payment of mandatory co-payment(s) sent to the recipient during the





course of a year shall establish a pattern of not meeting the mandatory cost sharing requirement of the program. The process to terminate eligibility shall proceed with the third failure to pay a mandatory co-payment in any one (1) year or until one (1) or more of the three (3) delinquent mandatory co-payments is made. Coverage shall begin again only after payment of one (1) or more of the three (3) co-payments or passage of six (6) months time whichever occurs first. Health care coverage shall not be retroactive.

1. A year starts at the time a co-payment is reported not paid to the Division of Medical Services;

2. Payment of a delinquent co-payment or co-payments will eliminate the failure to pay a mandatory co-payment or co-payments.

(H) Recipient(s) shall have access to a fair hearing process to appeal the disenrollment decision.

(I) If the recipient fails to pay the mandatory co-payments three (3) times within a year and is disenrolled from coverage the recipient shall not be eligible for coverage for six (6) months after the department provides notice to the recipient of disenrollment for failure to pay mandatory co-payments or until one (1) or more of the three (3) delinquent mandatory co-payments is paid. Coverage shall begin again only after payment of one (1) or more of the three (3) co-payments or passage of six (6) months whichever occurs first. Coverage shall not be retroactive.

(6) Uninsured women who do not qualify for other benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage are not required to pay a co-payment for services.

(7) The Department of Social Services, Division of Medical Services shall provide for granting an opportunity for a fair hearing to any applicant or recipient whose claim for benefits under the Missouri Medicaid Section 1115 Health Care Reform Demonstration Proposal is denied or disenrollment for failure to pay mandatory co-payments has been determined by the Division of Medical Services. There are established positions of state hearing officer within the Department of Social Services, Division of Legal Services in order to comply with all pertinent federal and state law and regulations. The state hearing officers shall have authority to conduct state level hearings of an appeal nature and shall serve as direct representative of the director of the Division of Medical Services.

*AUTHORITY: sections 208.040, RSMo Supp. 2001 and 208.201 and 660.017, RSMo 2000.\*  
Emergency rule filed Sept. 13, 1999, effective Sept. 23, 1999, terminated Oct. 15, 1999.  
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*\*Original authority: 208.040, RSMo 1939, amended 1941, 1949, 1951, 1953, 1955, 1957, 1973, 1977, 1982, 1983, 1984, 1987, 1994, 1999, 2001; 208.201, RSMo 1987; and 660.017, RSMo 1993, amended 1995.*