Missouri Department of
SOCIAL SERVICES
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MICHAEL L. PARSON, GOVERNOR • STEVE CORSI, Psy.D., DIRECTOR

MARK A. GUTCHEN, DIRECTOR
DIVISION OF LEGAL SERVICES
P.O. BOX 1527 • BROADWAY STATE OFFICE BUILDING• JEFFERSON CITY, MO 65102-1527
WWW.DSS.MO.GOV • 573-751-3229 • 573-522-6092 FAX

June 29, 2018

Waylene W. Hiles, Director
Joint Committee on Administrative Rules
Capitol Building, Room B-8
Jefferson City, MO 65101

RE: Periodic rule review pursuant to section 536.175, RSMo.

Dear Ms. Hiles:

Enclosed you will find the Missouri Department of Social Services' periodic rule review report. The Department began its formal review on July 1, 2017, and is submitting its report to the Joint Committee on Administrative Rules and the Small Business Regulatory Fairness Board, as required by section 536.175, RSMo. This report will also be made available on the Department's website.

During this review and the Executive Order 17-03 review, the Department identified a number of rules we are rescinding and amending. They are in various stages of the rulemaking process.

Should you have any questions, please contact Peggy Landwehr, Special Counsel, by email at peggy.landwehr@dss.mo.gov.

Sincerely,

Mark Gutchen, as designee for:
Steve Corsi, Psy.D.
Director
Department of Social Services

CC: Small Business Regulatory Fairness Board

Department of Social Services Periodic Rule Review

July 1, 2017 — June 30, 2018

Chapter 536.175, RSMo, Review Amended Report

Rule Number	Rule Title	Date of Adoption or Last Amendment	Does the rule continue to be necessary?	Is the rule Obsolete?	Does rule overlap, duplicate or conflict with other rules?	Can a less restrictive rule accomplish same purpose?	Can rule be modified to reduce regulatory burden or eliminate paperwork?	Does the rule properly incorporate material by reference?	For rules affecting small business: does the public purpose or interest for adopting justify continued existence of rule?	Appendix included? (For rules receiving public comment)	Page number of Appendix for Response	Number of Comments received on rule
13 CSR 5-1.030	Access for Inspection of Public Records and Fees for Copying of Public Records	2/29/2016	Yes	No	No	No	No	N/A	No	No	N/A	0
13 CSR 10-1.015	Direct Deposit of Payments	10/30/2015	No	Yes	No	No	Yes; rescinding	N/A	No	No	N/A	0
13 CSR 15-19.010	Standards for Inspeciton of Facilities or Premises Funded by Federal Departments Other Than Health and Human Services	11/11/1988	No	Yes	No	No	Yes; rescinding	N/A	No	No	N/A	0
13 CSR 30-1.010	Organization and Operation	5/30/2017	No	Yes	No	No	Yes; rescinded	N/A	N/A	No	N/A	0
13 CSR 30-2.010	Prosecuting Attorneys' Performance Standards	4/30/2011	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 30-2.020	Financial Performance Measures for Counties Under Contract With the Missouri Division of Child Support Enforcement for the Provision of Total Child Support Services in Local Jurisdictions (Level A Counties)	5/30/2017	No	Yes	No	No	Yes; rescinded	N/A	N/A	No	N/A	0
13 CSR 30-2.030	Standard Procedures for Handling Cash Receipts in Circuit Clerks' Office Under Contract With the Missouri Division of Child Support Enforcement for the Provision of IV-D Services	2/11/1990	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 30-2.040	Standard Procedures for Handling Cash Receipts in Prosecuting Attorneys' Offices Under Contract With the Missouri Division of Child Support Enforcement for the Provision of IV-D Services	2/11/1990	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 30-4.020	Immediate Income Withholding Exceptions for Administrative Orders	6/10/1991	Yes	No	No	No	Yes; amending	N/A	N/A	Yes	Page 1	1
13 CSR 30-5.010	Child Support Obligation Guidelines	12/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 30-5.020	Review and Modification of Child Support Orders	5/30/1996	Yes	No	No	No	Yes; amending	N/A	N/A	Yes	Page 1	1
13 CSR 30-6.010	Reporting of Child Support Debts to Consumer Reporting Agencies	9/30/1995	Yes	No	No	No	Yes; amending	N/A	N/A	Yes	Pages 1-3	1
13 CSR 30-7.010	Administrative Hearings	9/30/1995	Yes	No	No	No	Yes; amending	N/A	N/A	Yes	Page 3	1
13 CSR 30-8.010	Cooperation Requirement	10/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	Yes	Page 3	1
13 CSR 30-9.010	Incentives	9/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 30-10.010	Annual Fee	1/30/2002	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 35-30.010	Voluntary Placement Agreement Solely for the Purpose of Accessing Mental Health Services and Treatment for Children Under Age Eighteen (18)	6/30/2005	Yes	No	No	No	No	N/A	N/A	Yes	Pages 3-4	1
13 CSR 35-31.010	Definitions	11/30/2015	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 35-31.015	Investigations Involving a Conflict of Interest	2/29/2016	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 35-31.020	Screening and Classification of Child Abuse/Neglect Reports	11/30/2016	Yes	No	No	No	No	N/A	N/A	Yes	Pages 4-6	4
13 CSR 35-31.025	Child Abuse and Neglect Review Process	3/30/2008	Yes	No	No	No	Yes; amending	N/A	N/A	Yes	Pages 6-13	6
13 CSR 35-31.027	Juveniles With Problem Sexual Behaviors	8/30/2016	Yes	No	No	No	No	N/A	N/A	Yes	Pages 13-16	7
13 CSR 35-31.050	Consent to Termination of Parental Rights and/or Adoption	3/30/2017	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 35-32.010	Basis of Payment	8/30/2017	No	Yes	No	No	Yes; rescinded	N/A	N/A	Yes	Page 16	1
13 CSR 35-32.020	Foster Care Case Management Contracts	10/30/2011	Yes	No	No	Yes	No	N/A	Yes	Yes	Pages 16-20	5

Chapter 536.175, RSMo, Review Amended Report

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13 CSR 35-32.030	Contracted Foster Care Case Management Costs	10/30/2011	Yes	No	No	No	No	N/A	No	No	N/A	0
13 CSR 35.32.040	Hand-Up Pilot Program	11/30/2013	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 35-32.050	Definitions	8/30/2017	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-32.060	Eligibility and Authorization for Child Care Subsidy	8/30/2017	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 35-32.070	Registration Requirements for Child Care Providers Serving Four or Less Unrelated Children	8/30/2017	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-32.090	Requirements for Licensed Child Care Facilities to Contract for State or Federal Child Care Funds	8/30/2017	Yes	No	No	No	No	N/A	Yes	Yes	Pages 20-21	1
13 CSR 35-32.100	Participant Overpayments	8/30/2017	Yes	No	No	No	No	N/A	No	No	N/A	0
13 CSR 35-32.110	Child Care Provider Overpayments	8/30/2017	Yes	No	No	No	No	N/A	No	No	N/A	0
13 CSR 35-32.120	Regulatory and Contractual Violations of Registered Child Care Providers	8/30/2017	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-32.130	Recordkeeping	8/30/2017	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-34.080	Children's Income Disbursement System (KIDS)	4/30/2006	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 35.36.010	Alternative Care Review Board	4/30/2014	Yes	No	No	No	No	N/A	No	No	N/A	0
13 CSR 35-38.010	Adoption and Guardianship Subsidy	10/30/2010	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 35-38.011	Definition of Guardianship Services	11/30/2010	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 35-38.021	Provision of Guardianship Services	11/30/2010	No	Yes	Yes	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 35-38.030	Definition of Adoption Services	11/30/2010	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 35-38.040	Provision of Adoption Services	11/30/2010	No	Yes	Yes	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 35-50.010	Accreditation as Evidence for Meeting Licensing Requirements	6/30/2005	Yes	No	No	No	No	N/A	Yes	Yes	Page 21	1
13 CSR 35-60.010	Family Homes Offering Foster Care	3/30/2016	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 35-60.020	Capacity of Foster Homes	3/30/2016	Yes	No	No	No	No	N/A	N/A	Yes	Pages 21-25	5
13 CSR 35-60.030	Minimum Qualifications of Foster Parent(s)	3/30/2016	Yes	No	No	No	Yes; amending	N/A	N/A	Yes	Pages 26-28	3
13 CSR 35-60.040	Physical Standards for Foster Homes	3/30/2016	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 35-60.050	Care of Children	3/30/2016	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 35-60.060	Records and Reports	3/30/2016	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 35-60.070	Foster Care Services for Youth with Elevated Needs	10/30/2010	Yes	No	No	No	No	N/A	N/A	Yes	Page 28	1
13 CSR 35-60.080	Licensing Waivers for Relative Resource Providers	3/30/2016	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 35-60.090	Denial or Revocation of License	3/30/2016	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 35-60.100	Foster Care Services for Youth with Elevated Medical Needs	3/30/2016	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 35-60.110	Removal of a Parent from a Foster Parent License	3/30/2016	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 35-71.010	Definitions	6/30/2014	Yes	No	No	No	No	N/A	Yes	Yes	Page 29	2
13 CSR 35-71.020	Basic Residential Treatment for Children and Youth Core Requirements (Applicable to All Agencies) - Basis for Licensure and Licensing Procedures	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0

Chapter 536.175, RSMo, Review Amended Report

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13 CSR 35-71.025	Exemption of Religious Residential Treatment for Children and Youth Operating Sites	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.030	Hearings and Judicial Review	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.035	Court Review and Dispositional Hearing	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.040	Organization and Administration	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.045	Personnel	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.050	Staff Qualifications and Requirements	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.060	Social Services Program	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.070	Protection and Care of the Child	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.075	Health Care	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.080	Buildings, Grounds, and Equipment	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.090	Record Keeping	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.100	Specific Rules for Basic Care Agencies Providing Care for Infant, Toddler, or Preschool Age Children (Birth Through Age Six (6))	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.110	Child Care Program	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.120	Specific Rules for Residential Treatment Agencies for Children and Youth Providing Maternity Care	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.130	Specialized Standards - Residential Treatment for Children and Youth	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-71.140	Specialized Standards for Intensive Residential Treatment for Children and Youth	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-80.010	Residential Foster Care Maintenance Methodology	3/30/2005	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-80.020	Residential Care Agency Cost Reporting System	11/30/2005	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 35-100.010	Residential Treatment Agency Tax Credit	8/30/2013	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 35-100.020	Pregnancy Resourse Center Tax Credit	3/30/2007	Yes	No	No	No	Yes; amending	N/A	N/A	Yes	Page 30	1
13 CSR 35-100.030	Development Disability Care Provider Tax Credit	4/30/2013	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 40-1.010	Organization	5/30/2017	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.010	General Application Procedures	2/28/2014	Yes	No	No	Yes	Yes; amending	N/A	N/A	Yes	Pages 30-31	1
13 CSR 40-2.015	Authorized Representatives	12/30/2015	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.020	General Reinvestigation Procedures	5/11/1987	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.030	Definitions Relating to Real and Personal Property	4/30/2016	Yes	No	No	No	Yes; amending	N/A	N/A	Yes	Pages 31-38	2
13 CSR 40-2.040	Definition of Abandonment of Residence	11/14/1954	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.050	Definition of Earned Income	10/4/1970	Yes	No	No	Yes	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.060	Definitions Relating to AFDC	11/31/1991	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.070	Definitions Relating General Relief	10/26/1985	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-2.080	Definitions Relating to Institutions	11/30/1967	Yes	No	No	No	Yes; amended	N/A	N/A	No	N/A	0
13 CSR 40-2.090	Definitions Relating to Money Payments	2/12/1981	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0

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13 CSR 40-2.100	Definitions Relating to PTD	11/11/1950	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.110	Persons Whose Expenses and Income Are Included in Determining Cash Payments	6/11/1982	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.120	Methods Used to Determine the Amount of Cash Payments	1/31/1994	Yes	No	No	No	Yes; amending	No	N/A	Yes	Pages 38-40	2
13 CSR 40-2.130	Maximum Cash Payment Amounts	11/30/1990	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.140	Limitations on Amount of Cash Payments	12/30/2002	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.150	Date Cash Payments Are Due and Payable	11/30/1996	Yes	Yes	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.160	State Hearing Procedures	4/12/1990	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.170	Special Requirements for the AFDC Program	6/11/1982	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.180	Confidentiality of Case Records	5/14/1959	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.190	Procedure for Collection of Overpayments	5/11/1984	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.200	Determining Eligibility for Medical Assistance	1/30/2006	Yes	No	No	No	Yes; amending	No	N/A	No	N/A	0
13 CSR 40-2.210	State Emergency Assistance Program	12/11/1980	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.220	Families Deemed to be Receiving AFDC for Purposes of Title XIX	4/12/1990	No	No	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-2.230	Disposal of Excess Real Property	2/13/1986	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.260	Newborns Deemed to be Eligible for Title XIX	8/30/1991	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.270	Determining Eligibility for Qualified Medicare Beneficiaries	7/8/1991	Yes	No	No	No	No	No	N/A	No	N/A	0
13 CSR 40-2.280	FUTURES Program	11/30/1995	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-2.290	Compensation for Legal Representation of General Relief Recipient in Successful Supplemental Security Income Appeal	4/29/1991	No	No	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-2.300	Definitions Which Are Applicable for Benefit Programs Funded by the Temporary Assistance for Needy Families (TANF) Block Grant	4/30/2016	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.305	Prohibition Against the Payment of Temporary Assistance to a Person Who Has Been Convicted of Certain Felony Drug Offenses	8/1/1998	Yes	No	No	No	No	N/A	N/A	Yes	Pages 40-41	1
13 CSR 40-2.310	Requirements as to Eligibility for Temporary Assistance (TA)	4/30/2016	Yes	No	No	No	No	N/A	N/A	Yes	Pages 41-45	2
13 CSR 40-2.315	Work Activity and Work Requirements for Recipients of Temporary Assistance	4/30/2016	Yes	No	No	No	No	N/A	N/A	Yes	Pages 45-48	2
13 CSR 40-2.320	Prohibition Against Displacing Existing Workers Through Work Activities Associated with the Temporary Assistance Program	8/1/1998	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.325	Prohibition Against Payment of Temporary Assistance to Families That Do Not Include a Minor Child	4/30/2016	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.330	Reduction of Temporary Assistance for Noncooperation in Establishing Paternity or Obtaining Child Support	8/1/1998	Yes	No	No	No	No	N/A	N/A	No	N/A	0

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13 CSR 40-2.335	Assignment of Certain Support Rights as a Condition for the Receipt of Temporary Assistance	8/1/1998	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.340	Prohibition Against Payment of Temporary Assistance to Teenage Parents Who Do Not Attend High School or Other Equivalent Training	8/1/1998	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.345	Prohibition Against Payment of Temporary Assistance to Teenage Parents Not Living in Adult Supervised Settings	8/1/1998	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.350	Time Limit for Receipt of Tempory Assistance	8/30/2016	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.355	Prohibition Against Payment of Temporary Assistance Benefits to a Person Found to Have Fraudulently Misrepresented Residence in Order to Obtain Assistance in Two	8/1/1998	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.357	Tempory Assistance Diversion Program	7/30/2016	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.360	Prohibition Against Payment of Temporary Assistance to Certain Persons Fleeing to Avoid Prosecution, or Custody or Confinement After Conviction	8/1/1998	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.365	Prohibition Against Payment of Temporary Assistance on Behalf of Minor Children Who Are Absent from the Home for a Significant Period of Time	8/1/1998	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.370	Requirement that All Recipients for the Payment of Temporary Assistance Shall Complete an Assessment and May Be Required To Complete an Individual Employment Plan	4/30/2011	Yes	No	No	No	No	N/A	N/A	Yes	Pages 48-50	1
13 CSR 40-2.375	Medical Assistance for Families	12/30/2015	No	Yes	Yes	No	Yes; rescinding	N/A	N/A	Yes	Pages 50-51	1
13 CSR 40-2.390	Transitional Employment Benefit	5/30/2009	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.395	Spend Down Program	10/30/2012	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-2.400	Definitions for the Screening and Testing for the Illegal Use of Controlled Substances by Temporary Assistance Applicants and Recipients	2/28/2013	No	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.410	Screening Temporary Assistance Applicants and Recipients for Illegal Use of a Controlled Substance	4/30/2015	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.420	Testing for the Illegal Use of a Controlled Substance by Applicants and Recipients of Temporary Assistance	4/30/2015	Yes	No	No	No	No	N/A	N/A	Yes	Pages 51-52	1
13 CSR 40-2.430	Substance Abuse Treatment Program for Temporary Assistance Recipients	2/28/2013	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-2.440	Hearings for Proceedings under 13 CSR 40-2.400 through 13 CSR 40-2.450	4/30/2015	Yes	No	No	No	No	N/A	N/A	No	N/A	0

Chapter 536.175, RSMo, Review Amended Report

Rule Number	Rule Title	Date of Adoption or Last Amendment	Does the rule continue to be necessary?	Is the rule Obsolete?	Does rule overlap, duplicate or conflict with other rules?	Can a less restrictive rule accomplish same purpose?	Can rule be modified to reduce regulatory burden or eliminate paperwork?	Does the rule properly incorporate material by reference?	For rules affecting small business: does the public purpose or interest for adopting justify continued existence of rule?	Appendix included? (For rules receiving public comment)	Page number of Appendix for Response	Number of Comments received on rule
13 CSR 40-2.450	Assignment of a Protective Payee Over Temporary Assistance Benefits When the Head-of-Household is Declared Ineligible for Temporary Assistance Pursuant to 13 CSR 40-2.400 through 13 CSR 40-2.440	2/28/2013	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-3.010	Reimbursable Expenditures	6/30/2009	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-3.020	Minimum Record-Keeping Requirements for County Reimbursement and Standardization of Claims Submissions	6/30/2009	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-7.010	Scope and Definitions	2/28/2014	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-7.015	Application Procedure for Family MO HealthNet Programs and the Children's Health Insurance Program (CHIP)	2/28/2014	Yes	No	Yes	No	Yes; amending	N/A	N/A	Yes	Pages 52-65	6
13 CSR 40-7.020	Household Composition	2/28/2014	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-7.030	Calculation of Modified Adjusted Gross Income (MAGI)	2/28/2014	Yes	No	No	No	No	N/A	N/A	Yes	Page 65	1
13 CSR 40-7.035	Participant Verification	10/30/2014	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-7.040	Verification Procedures	2/28/2014	Yes	No	No	No	No	N/A	N/A	Yes	Pages 66-70	3
13 CSR 40-7.050	Presumptive Eligibility	9/30/2016	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-7.060	Show-Me Healthy Babies	6/30/2016	No	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-8.020	Ways of Treating Income and Assets	6/30/2017	Yes	No	Yes	No	No	N/A	N/A	No	N/A	0
13 CSR 40-13.020	Vision Re-examination	7/30/2015	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-13.040	Blind Pension Prescription Drug Coverage	5/30/2015	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-15.455	Eligibility for Individual with a Drug Felony Conviction	4/30/2017	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 40-19.020	Low Income Home Energy Assistance Program (LIHEAP) and Utilicare	5/30/2017	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 40-24.080	Formula for the Distribution of Community Service Block Grant Funds to Community Action Agencies	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 40-24.090	Supplemental Funding Formula for Community Action Agencies to Administer the CSBG Program	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 40-24.100	Use of Community Service Block Grant Discretionary Funds	6/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 40-30.010	Case Plan	11/11/1983	Yes	Yes	No	Yes	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-30.020	Attorney Fees in Termination of Parental Rights Cases	6/30/2003	Yes	Yes	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 40-30.030	Attorney Fees and Guardian Ad Litem Fees in Subsidized Adoption and Guardianship Cases	12/20/2002	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-32.020	Processing of Applications for State and Federal Funds for Providing Child Care Services	6/30/2001	No	Yes	Yes	No	Yes; rescinding	N/A	Yes	No	N/A	0
13 CSR 40-34.012	Rates for Foster Care	11/11/1983	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-34.060	Parental Support	11/11/1982	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0

Chapter 536.175, RSMo, Review Amended Report

Rule Number	Rule Title	Date of Adoption or Last Amendment	Does the rule continue to be necessary?	Is the rule Obsolete?	Does rule overlap, duplicate or conflict with other rules?	Can a less restrictive rule accomplish same purpose?	Can rule be modified to reduce regulatory burden or eliminate paperwork?	Does the rule properly incorporate material by reference?	For rules affecting small business: does the public purpose or interest for adopting justify continued existence of rule?	Appendix included? (For rules receiving public comment)	Page number of Appendix for Response	Number of Comments received on rule
13 CSR 40-34.070	Payment to School Districts for Special Education Services for Children in the Custody of the Division of Family Services and Placed in Residential Treatment Facilities	12/28/1989	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-36.001	Foster/Relative/Adoptive Parent Grievance Process	11/11/1983	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-37.010	Basis for Provision	11/11/1979	No	Yes	Yes	No	Yes; rescinded	N/A	N/A	No	N/A	0
13 CSR 40-50.010	Family Home Offering Foster/Adoptive Care	3/25/1988	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-59.020	Definitions	6/28/1990	No	Yes	Yes	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-59.030	Criminal and Child Abuse/Neglect Central Registry Checks for Foster, Adoptive, and Relative Care Providers	6/28/1990	No	Yes	Yes	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-59.040	Definitions in Release of Information	6/28/1990	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-59.050	Child Abuse/Neglect Central Registry Checks for Child Care Employees and Volunteers	12/9/1993	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-61.065	Child Care Licensing Review Board	10/31/1991	No	Yes	Yes	Yes	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-61.075	Hearings and Judicial Review	10/31/1991	No	Yes	Yes	Yes	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-62.062	Child Care Licensing Review Board	10/31/1991	No	Yes	Yes	Yes	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-62.072	Hearings and Judicial Review	10/31/1991	No	Yes	Yes	Yes	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 40-72.010	Group Homes Offering Residential Care	12/28/1989	Yes	No	No	No	Yes; amending	No	Yes	No	N/A	0
13 CSR 40-73.010	Definitions	7/30/1997	Yes	No	No	No	Yes; amending	N/A	Yes	Yes	Page 70	1
13 CSR 40-73.012	Basis for Licensure and Licensing Procedures	7/30/1997	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 40-73.015	Exemption of Child Placing Agencies From Licensure	7/30/1997	Yes	No	No	No	Yes; rescinding	N/A	Yes	No	N/A	0
13 CSR 40-73.017	Hearings and Judicial Review	7/30/1997	Yes	No	No	No	In addition	N/A	Yes	No	N/A	0
13 CSR 40-73.018	Court Review and Dispositional Hearing	7/30/1997	Yes	No	No	No	Yes; rescinding	N/A	Yes	No	N/A	0
13 CSR 40-73.020	Organization and Administration	7/30/1997	Yes	No	No	No	In addition	N/A	Yes	No	N/A	0
13 CSR 40-73.030	Personnel Practices and Personnel	7/30/1997	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 40-73.035	Qualifications and Requirements	7/30/1997	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 40-73.040	Operational Requirements	7/30/1997	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 40-73.050	Protection and Care of the Child	7/30/1997	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 40-73.055	Health Care	7/30/1997	Yes	No	No	No	In addition	N/A	Yes	Yes	Page 70	1
13 CSR 40-73.060	Recommendation for Foster Homes Licensing	7/30/1997	Yes	No	No	No	Yes; amending	N/A	Yes	Yes	Pages 70-71	1
13 CSR 40-73.070	Placement of Children in Foster Family Homes	7/30/1997	Yes	No	No	No	Yes; amending	N/A	Yes	Yes	Page 71	1
13 CSR 40-73.075	Foster Care Services	7/30/1997	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 40-73.080	Adoption Services	7/30/1998	Yes	No	No	No	Yes; amending	No	Yes	No	N/A	0
13 CSR 40-79.010	Domestic Violence Shelter Tax Credit	3/30/2007	Yes	No	No	No	Yes; amending	N/A	N/A	Yes	Pages 71-75	6
13 CSR 40-80.010	Maternity Home Tax Credit	4/30/2000	Yes	No	No	No	Yes; rescinding and proposing a new amendment	N/A	N/A	No	N/A	0
13 CSR 40-91.010	Business Enterprise Program	11/30/1995	Yes	No	No	Yes	Yes; amending	No	Yes	No	N/A	0
13 CSR 40-91.020	Vocational Rehabilitation for the Blind	3/30/1995	Yes	No	No	Yes	Yes; amending	No	N/A	No	N/A	0

Chapter 536.175, RSMo, Review Amended Report

Rule Number	Rule Title	Date of Adoption or Last Amendment	Does the rule continue to be necessary?	Is the rule Obsolete?	Does rule overlap, duplicate or conflict with other rules?	Can a less restrictive rule accomplish same purpose?	Can rule be modified to reduce regulatory burden or eliminate paperwork?	Does the rule properly incorporate material by reference?	For rules affecting small business: does the public purpose or interest for adopting justify continued existence of rule?	Appendix included? (For rules receiving public comment)	Page number of Appendix for Response	Number of Comments received on rule
13 CSR 40-91.030	Prevention of Blindness program	2/28/2001	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 40-91.040	Payments for vision exams	3/30/2011	No	Yes	No	No	Yes; rescinded	N/A	N/A	No	N/A	0
13 CSR 40-100.040	State Directory of New Hires	2/28/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 40-110.030	Annual Twenty-Five Dollar ($25) Fee	2/29/2008	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 45-2.010	Organization and Operation	6/30/2001	Yes	No	No	No	Yes; amending	N/A	N/A	Yes	Pages 75-79	5
13 CSR 65-2.010	Definitions	7/30/2014	Yes	No	Yes	No	No	N/A	Yes	No	N/A	0
13 CSR 65-2.020	Provider Enrollment and Application	11/30/2015	Yes	No	Yes	No	No	Yes	Yes	No	N/A	0
13 CSR 65-2.030	Denial or Limitations of Applying Provider	7/30/2014	Yes	No	Yes	No	No	N/A	Yes	No	N/A	0
13 CSR 65-3.050	Electonic Signatures for Mo HealthNet Program	11/30/2017	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-1.010	Organization	10/30/2006	Yes	No	No	No	No	Yes	Yes	Yes	Pages 79-83	2
13 CSR 70-1.020	Personal Identifiable Health Information	10/30/2014	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-2.100	Title XIX Procedure of Exception to Medical Care Services Limitations	4/30/2007	Yes	No	No	No	Yes; amending	Yes	Yes	No	N/A	0
13 CSR 70-2.200	Organ and Transplant	9/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-3.020	Title XIX Provider Enrollment	12/30/2010	Yes	No	No	No	No	N/A	No	Yes	Page 83	1
13 CSR 70-3.030	Sanctions for False or Fraudulent Claims for MO HealthNet Services	5/30/2017	Yes	No	No	No	Yes; amended	No	Yes	Yes	Pages 83-90	2
13 CSR 70-3.040	Duty of Medicaid Participating Hospitals and Other Vendors to Assist in Recovering Third-Party Payments	9/11/1977	No	Yes	Yes	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-3.050	Obtaining Information From Providers of Medical Services	10/9/1975	Yes	No	No	No	No	N/A	No	No	N/A	0
13 CSR 70-3.100	Filing of Claims, MO HealthNet Program	2/28/2010	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 70-3.105	Timely Payment of MO HealthNet Claims	1/30/2009	Yes	No	No	No	No	N/A	No	No	N/A	0
13 CSR 70-3.120	Limitations on Payment of Out-of-State Nonemergency Medical Services	11/30/2009	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-3.130	Computation of Provider Overpayment by Statistical Sampling	2/28/2011	Yes	No	No	No	Yes; rescinding and proposing a new amendment	N/A	Yes	No	N/A	0
13 CSR 70-3.140	Direct Deposit of Provider Reimbursement	12/30/2010	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-3.150	Authorization To Receive Payment for Medicaid Services	1/30/1999	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-3.160	Electronic Submission of MO HealthNet Claims and Electronic Remittance Advices	12/30/2010	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-3.170	Medicaid Managed Care Organization Reimbursement Allowance	1/30/2010	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-3.180	Medical Precertification Process	3/2/2009	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-3.190	Telehealth Services	8/30/2009	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-3.200	Ambulance Service Reimbursement Allowance	4/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-3.210	Electronic Retention of Records	12/30/2011	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-3.220	Electronic Health Record Incentive Program	7/1/2011	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-3.230	Payment Policy for Provider Preventable Conditions	6/30/2012	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0

Chapter 536.175, RSMo, Review Amended Report

Rule Number	Rule Title	Date of Adoption or Last Amendment	Does the rule continue to be necessary?	Is the rule Obsolete?	Does rule overlap, duplicate or conflict with other rules?	Can a less restrictive rule accomplish same purpose?	Can rule be modified to reduce regulatory burden or eliminate paperwork?	Does the rule properly incorporate material by reference?	For rules affecting small business: does the public purpose or interest for adopting justify continued existence of rule?	Appendix included? (For rules receiving public comment)	Page number of Appendix for Response	Number of Comments received on rule
13 CSR 70-3.240	MO HealthNet Primary Care Health Homes	6/30/2017	Yes	No	No	No	No	No	Yes	No	N/A	0
13 CSR 70-3.250	Payment Policy for Early Elective Delivery	9/30/2014	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-3.260	Payment Policy for Asthma Education and In-Home Environmental Assessments	1/30/2017	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-4.030	Participant Liability for Medical Services Not Reimbursable to the Provider by the MO HealthNet Agency	4/30/2008	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-4.040	Eligibility Corrective Action Participant Payments	4/30/2008	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-4.050	Copayment and Coinsurance for Certain Medicaid-Covered Services	11/30/2000	Yes	No	Yes	No	No	N/A	Yes	No	N/A	0
13 CSR 70-4.051	Copayment for Pharmacy Services	11/30/2000	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 70-4.060	Required Reporting of Injuries Received by Title XIX Recipients	11/11/1982	Yes	No	Yes	No	No	N/A	Yes	No	N/A	0
13 CSR 70-4.070	Title XIX Recipient Lock-In Program	2/29/2004	Yes	No	No	No	Yes; Rescinding	N/A	Yes	No	N/A	0
13 CSR 70-4.080	State Children's Health Insurance Program	3/30/2015	Yes	No	Yes	No	No	N/A	Yes	No	N/A	0
13 CSR 70-4.090	State-Funded Missouri Woman's Health Services Program	4/30/2017	Yes	No	No	No	No	Yes	No	No	N/A	0
13 CSR 70-4.100	Preventing Medicaid Payment of Expenses Used to Meet Spend- down	10/30/2015	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-4.110	Placement of Liens on Property of Certain Institutionalized MO HealthNet Eligible Persons	6/30/2012	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-4.120	Department is the Payer of Last Resort, Department's Lien for Recovery, Participant's Duty of Cooperation	9/26/2013	Yes	No	No	No	No	Yes	N/A	No	N/A	0
13 CSR 70-5.010	Non Emergency Medical Transportation Services	7/31/2008	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-6.010	Emergency Ambulance Program	2/28/2009	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-10.005	Reasonable Cost-Related Reimbursement Plan for Long-Term Care	1/14/1982	Yes	No	Yes	No	No	No	Yes	No	N/A	0
13 CSR 70-10.010	Prospective Reimbursement Plan for Long-Term Care	5/28/1995	Yes	No	Yes	No	No	No	Yes	No	N/A	0
13 CSR 70-10.015	Prospective Reimbursement Plan for Nursing Facility Services	4/30/2016	Yes	No	No	No	No	Yes	Yes	Yes	Pages 90-91	1
13 CSR 70-10.016	Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates	11/30/2016	Yes	No	No	No	Yes; amending	Yes	Yes	No	N/A	0
13 CSR 70-10.017	Nursing Facility Invasive Ventilator Program	10/30/2013	Yes	No	No	No	Yes; amending	Yes	Yes	No	N/A	0
13 CSR 70-10.030	Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services	3/30/2017	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-10.040	Medicaid Eligibility and Preadmission Screening for Mentally Ill and Mentally Retarded Individuals	1/30/2000	Yes	Yes	No	No	Yes; amending	No	Yes	No	N/A	0
13 CSR 70-10.050	Pediatric Nursing Care Plan	5/30/2002	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-10.060	Retrospective Reimbursement Plan for State-Operated Facilities for ICF/MR Services	3/30/2008	Yes	No	No	No	No	Yes	Yes	No	N/A	0

Chapter 536.175, RSMo, Review Amended Report

Rule Number	Rule Title	Date of Adoption or Last Amendment	Does the rule continue to be necessary?	Is the rule Obsolete?	Does rule overlap, duplicate or conflict with other rules?	Can a less restrictive rule accomplish same purpose?	Can rule be modified to reduce regulatory burden or eliminate paperwork?	Does the rule properly incorporate material by reference?	For rules affecting small business: does the public purpose or interest for adopting justify continued existence of rule?	Appendix included? (For rules receiving public comment)	Page number of Appendix for Response	Number of Comments received on rule
13 CSR 70-10.070	Limitations on Allowable Nursing Facility Costs to Reserve a Bed for Absences Due to Hospital Admission	6/6/1994	Yes	No	No	No	Yes; amending	Yes	Yes	No	N/A	0
13 CSR 70-10.080	Prospective Reimbursement Plan for HIV Nursing Facility Services	9/30/2010	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-10.100	Limitation on Allowable Capital Cost Overruns for New Institutional Health Services in Title XIX Reimbursement Rate Setting	11/11/1982	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-10.110	Nursing Facility Reimbursement Allowance	1/30/2016	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-10.120	Reimbursement for Nurse Assistant Training	9/30/1996	Yes	No	No	No	Yes; amending	Yes	Yes	No	N/A	0
13 CSR 70-10.150	Enhancement Pools (Nursing Home Program)	4/30/2002	No	Yes	No	No	Yes; rescinded	N/A	No	No	N/A	0
13 CSR 70-10.160	Public/Private Long-Term Care Services and Supports Partnership Supplemental Payment to Nursing Facilities	2/28/2015	Yes	No	No	No	Yes; amending	Yes	Yes	No	N/A	0
13 CSR 70-15.010	Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology	1/30/2017	Yes	No	No	Yes	Yes; amending	Yes	Yes	No	N/A	0
13 CSR 70-15.020	Procedures for Admis- sion Certification, Continued Stay Review and Validation Review of Hospital Admissions	4/30/2016	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-15.030	Payment and Payment Limitations for Inpatient Hospital Care	11/30/2016	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-15.040	Inpatient Hospital and Outpatient Hospital Settlements	1/30/2003	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 70-15.070	Inpatient Hospital Psychiatric Services for Individuals Under Age Twenty-One	12/9/1991	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-15.090	Procedures for Evaluation of Appropriate Inpatient Hospital Admissions and Continued Days of Stay	11/30/1990	Yes	No	No	No	Yes; amended	N/A	Yes	No	N/A	0
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA)	1/30/2017	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 70-15.150	Enhancement Pools	9/30/2001	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-15.160	Prospective Outpatient Hospital Services Reimbursement Methodology	1/30/2014	Yes	No	No	Yes	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 70-15.190	Out-of-State Hospital Services Reimbursement Plan	10/30/2014	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-15.220	Disproportionate Share Hospital Payments	8/30/2017	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-15.230	Supplemental Upper Payment Limit Methodology	1/30/2012	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-20.010	Participating Drug Vendors	2/11/1979	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-20.030	Drugs Covered by Medicaid	12/30/2000	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 70-20.031	List of Excludable Drugs for Which Prior Authorization Is Required	3/30/2014	Yes	No	No	No	Yes; amending	No	Yes	No	N/A	0
13 CSR 70-20.032	List of Excludable Drugs Excluded From Coverage Under the MO HealthNet Pharmacy Program	3/30/2014	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-20.033	Medicaid Program Coverage of Investigational Drugs Used in the Treatment of Acquired Immunodeficiency Syndrome (AIDS)	7/30/1996	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0

Chapter 536.175, RSMo, Review Amended Report

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13 CSR 70-20.034	List of Non-Excludable Drugs for Which Prior Authorization Is Required	2/28/2010	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-20.040	Five Prescription Limit Per Month Per Recipient	10/31/1991	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-20.045	Thirty-One Day Supply Maximum Restriction on Pharmacy Services Reimbursed by the Division of Medical Services	6/30/2001	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 70-20.050	Return of Drugs	3/30/2014	Yes	No	No	No	Yes; amending	No	Yes	No	N/A	0
13 CSR 70-20.060	Professional Dispensing Fee	3/30/2014	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 70-20.070	Computer-Generated Drug Pricing Tape and Drug Reimbursement Methodology	6/30/2001	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 70-20.071	Multiple Source Drugs for Which There Exists a Federal Upper Limit on Reimbursement	3/30/2014	No	Yes	Yes	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-20.200	Drug Prior Authorization Process	3/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-20.250	Prior Authorization of New Drug Entities or New Drug Dosage Form	3/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-20.300	Retrospective Drug Use Review Process	3/30/2014	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-20.310	Prospective Drug Use Review Process and Patient Counseling	3/30/2014	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 70-20.320	Pharmacy Reimbursement Allowance	6/30/2010	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 70-20.330	Medication Therapy Management (MTM) Program	1/30/2016	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-20.340	National Drug Code Requirement	2/29/2016	Yes	No	No	No	Yes; amending	N/A	Yes	No	N/A	0
13 CSR 70-25.100	Abortions	10/11/1981	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-25.110	Payment for Early Periodic Screening, Diagnostic and Treatment Program Services	2/28/2009	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-25.120	MO HealthNet (Medicaid) Payment for Certain Services Furnished by Certain Physicians in Calendar Years 2013 and 2014	4/30/2014	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-26.010	MO HealthNet Program Benefits for Federally-Qualified Health Center Services	12/30/2011	Yes	No	No	No	Yes; amending	Yes	Yes	No	N/A	0
13 CSR 70-30.010	Podiatric Services Program	5/30/2009	Yes	No	No	No	Yes; amending	Yes	Yes	No	N/A	0
13-CSR 70-35.010	Dental Benefits and Limitations	4/12/2016	Yes	No	No	No	No	Yes	N/A	Yes	Pages 91-92	1
13 CSR 70-40.010	Optical Benefits and Limitations	4/30/2014	Yes	No	No	No	No	Yes	Yes	Yes	Page 92	1
13 CSR 70-45.010	Hearing Aid Program	4/30/2014	Yes	No	No	No	No	Yes	Yes	No	N/A	0
13 CSR 70-50.010	Hospice Services Program	3/30/2014	Yes	No	No	No	No	Yes	Yes	Yes	Page 92	1
13 CSR 70-55.010	MO HealthNet Program Benefits for Nurse-Midwife Services	11/30/2009	Yes	No	No	No	No	Yes	Yes	Yes	Page 92-95	6
13 CSR 70-60.010	Durable Medical Equipment Program	3/30/2014	Yes	No	No	No	No	Yes	No	Yes	Page 95	1
13-CSR 70-65.010	Rehabilitation Center Program	8/15/2014	Yes	No	No	No	No	Yes	N/A	No	N/A	0
13-CSR 70-70.010	Therapy Program	9/26/2013	Yes	No	No	No	No	Yes	N/A	No	N/A	0
13 CSR 70-90.010	Home Health-Care Services	11/30/2015	Yes	No	No	No	No	Yes	No	Yes	Page 95	1
13 CSR 70-90.020	Home Health-Care Services Reimbursement	5/1/2015	Yes	No	No	No	No	Yes	N/A	No	N/A	0
13 CSR 70-91.010	Personal Care	10/30/2005	Yes	No	No	No	No	N/A	Yes	Yes	Pages 96-103	3

Chapter 536.175, RSMo, Review Amended Report

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13 CSR 70-91.020	Mental Health Residential Personal Care Program	11/30/2010	No	Yes	No	No	Yes; rescinded	N/A	N/A	No	N/A	0
13 CSR 70-93.010	Reimbursement for Medicaid Children's Clinic Services	8/9/1993	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-93.020	Reimbursement for Medicaid Family Health Clinic Program	1/30/1996	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 70-94.010	Independent Rural Health Clinic Program	2/28/2009	Yes	No	No	No	Yes; amending	N/A	No	No	N/A	0
13 CSR 70-94.020	Provider-Based Rural Health Clinic	2/28/2009	Yes	No	No	No	Yes; amending	No	Yes	No	N/A	0
13 CSR 70-95.010	Private Duty Nursing Under the Healthy Children and Youth Program	2/28/2010	Yes	No	No	No	No	Yes	Yes	Yes	Pages 103-105	1
13 CSR 70-96.010	Reimbursement for Medicaid Primary and Prenatal Care Clinic Program	8/28/1994	No	Yes	No	No	Yes; rescinded	N/A	N/A	No	N/A	0
13 CSR 70-97.010	Health Insurance Premium Payment (HIPP) Program	12/1/2010	Yes	No	No	No	No	Yes	N/A	No	N/A	0
13 CSR 70-98.015	Behavioral Health Services Program Documentation	3/30/2014	Yes	No	Yes	No	Yes; amending	Yes	No	Yes	Page 105	2
13 CSR 70-98.020	Prior Authorization Process for Non-Pharmaceutical Behavioral Health Services	4/30/2014	Yes	No	No	Yes	Yes; amending	Yes	Yes	Yes	Page 106	1
13 CSR 70-98.030	Applied Behavior Analysis Services	7/30/2016	Yes	No	No	No	Yes; amending	Yes	Yes	No	N/A	0
13 CSR 70-99.010	Comprehensive Day Rehabilitation Program	4/30/2008	Yes	No	No	No	No	Yes	No	No	N/A	0
13 CSR 70-100.010	Missouri Rx Plan Benefits and Limitations	2/28/2015	Yes	No	No	No	No	N/A	Yes	No	N/A	0
13 CSR 110-1.010	General Organization	8/30/2000	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 110-2.010	Regional Classification Services	8/30/2000	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 110-2.030	Special or Unique Service Needs	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-2.040	Classification Criteria for Placement into Division of Youth Services (DYS) Programs	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-2.050	Transfers from One DYS Residential Facility to Another DYS Facility	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-2.060	Furlough Policies and Procedures	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-2.080	Runaway and Absconding Youth	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-2.100	Grievance Procedures for Committed Youths	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-2.110	Responsibilities of Facility Managers	8/30/2000	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 110-2.120	Administrative Decisions Affecting the Constitutional Rights	8/30/2000	Yes	No	Yes	Yes	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-2.130	Release of Youths from DYS Facilities	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-2.140	Confidentiality of Case Records	8/30/2000	Yes	No	No	No	No	N/A	N/A	No	N/A	0
13 CSR 110-2.150	Division of Youth Services Staff Training Programs	8/30/2000	Yes	No	No	No	No	N/A	N/A	Yes	Pages 106-107	1
13 CSR 110-3.010	Individual Treatment Plans	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-3.015	Safe Schools Act Procedures	8/30/2000	Yes	No	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 110-3.020	Aftercare Involvement During Residential Treatment	8/30/2000	Yes	No	No	No	Yes; rescinding	N/A	N/A	No	N/A	0
13 CSR 110-3.030	Aftercare Supervision	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-3.040	Revocation of Aftercare Supervision	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-3.050	Instructions for the Implementation of Revocation Procedure	8/30/2000	Yes	No	No	No	Yes; amending	No	N/A	No	N/A	0

Chapter 536.175, RSMo, Review Amended Report

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13 CSR 110-3.060	Grievance Procedure for Youth in Aftercare	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-4.010	Operational Procedures of the Interstate Compact on Juveniles	1/9/1976	No	Yes	No	No	Yes; rescinding	No	N/A	No	N/A	0
13 CSR 110-5.010	Dual Jurisdiction Procedures	8/30/2000	Yes	No	No	No	Yes; amending	N/A	N/A	No	N/A	0
13 CSR 110-6.010	Juvenile Crime Bill Provisions and Procedures	8/30/2000	No	Yes	No	No	Yes; rescinding	N/A	N/A	No	N/A	0

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MICHAEL L. PARSON, GOVERNOR • STEVE CORSI, Psy.D., DIRECTOR

MARK A. GUTCHEN, DIRECTOR
DIVISION OF LEGAL SERVICES
P.O. BOX 1527 • BROADWAY STATE OFFICE BUILDING• JEFFERSON CITY, MO 65102-1527
WWW.DSS.MO.GOV • 573-751-3229 • 573-522-6092 FAX

§536.175, RSMo, Regulation Review Comment Appendix

Comment 1
13 CSR 30-4.020 Immediate Income Withholding Exceptions for Administrative Orders

Absent parent old verbiage needs to be updated. Update division of child support enforcement. AFDC needs to be updated. DFS needs to be updated.

Response:

Thank you for your comments regarding the Family Support Division's (FSD's) regulation 13 CSR 30-4.020. FSD agrees that the identified terminology needs to be updated and these changes have been included in the most recently drafted version of a proposed amendment to this rule.

Comment 2
13 CSR 30-5.020 Review and Modification of Child Support Orders

Update AFDC, Update DCSE. Review should be conducted no less than 36 months from the "date of the order"

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 30-5.020. FSD agrees that the identified terminology needs to be updated and these changes have been included in the most recently drafted version of a proposed amendment to this rule. Language has also been suggested that addresses your comment regarding the review language.

Comment 3
13 CSR 30-6.010 Reporting of Child Support Debts to Consumer Reporting Agencies

Child support enforcement incorrectly reported one late payment on my husbands credit report. When he contacted them, the worker he spoke to had no idea how to remove it from the credit bureaus. The department has no problem reporting to credit bureaus (even incorrect information) but didn't know how to remove it. I personally experienced stress or frustration I spent too much time trying to follow the government requirement. This one incorrect reporting on my credit bureau caused a bank to deny my application for a home loan. Child support enforcement employees need to keep accurate records and if they do make a mistake, own up to it and take the necessary steps to correct it as soon as possible.

In our particular case, Child Support incorrectly reported that my husband was $450 in arrears of his support obligation to credit bureaus. It took four months of calling, faxing and emailing documentation to this agency the forms they generated and mailed to us, yet acted like we were incorrect. After months of mounted frustration, denial of a home construction loan because of their incorrect reporting, and many hours spent on the phone with them and more time sending them the paperwork they generated (which should mean they have copies of), and their workers telling us they have no idea how information gets reported to credit bureaus (one worker actually said "the computer automatically does it". My husband repeatedly told the lady that "someone" inputs that info into the computer, and asked who the person in that department is that enters data into their computers? The employee seemed very confused and had no idea and kept repeating that the computer does it by itself.

In addition, the initial contact with this agency was not only frustrating, but almost comical. An agency that has the power to destroy our plans to build a home due to one incorrect report generated by their "computer" to the credit bureaus, is not only incompetent, but when my husband asked the name of the employee, the answer he received was "operator". The employee refused to provide his name. The statute states one must be two months delinquent and $1000 or more in arrearage to report to credit bureaus. Yet they reported an arrearage amount of $450 (which was completely incorrect, he was current with zero balance) and even when we provided them this info, it took them four months to remove it from my husbands credit report. Our home loan was denied because of this one reporting error, the only negative report on my husbands credit report!

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 30-6.010. FSD has reviewed your feedback and provided a training review to our staff who answer incoming phone calls. There is a long standing procedure in place to correct inaccurate reporting in the rare instance that it occurs and it has been reiterated to our staff. The initial reporting to credit bureaus is an automated process within our case management system. Customers are notified 30 days prior to CRA reporting and provided information about the appeals process.

For reference: CS Procedural Manual Section VI, Chapter 9

IV. <u>Enforcement</u>

Based on the above criteria, MACSS will evaluate all unique case/order combinations during the nightly enforcement batch processing. MACSS will create an available CRA remedy for all eligible case/order combinations that do not already have an existing CRA remedy. If the case/order combination has an existing remedy, but the remedy is terminated or suspended and criteria are met, MACSS will create another CRA remedy.

A. Initiation

Without staff intervention, MACSS:

1. Identifies case/order combinations meeting criteria for the CRA referral, and creates the remedy;
2. Sends an "Enforcement Actions Available" alert to the CSS;
3. Automatically enforces the remedy on the *Enforcement Available Remedies* (ENFAR) screen and the *Enforcement Action List* (ENFAL) screen;
4. Generates the *Notice of Consumer Reporting Agency Referral* (CS-910) to the CSS's local printer; and
5. Completes related entries on DIARY.
   The CSS will retrieve the forms from the local printer and review the case/order to confirm that the referral is appropriate

http://dssweb/fsd/csepolicy/manpolicydocs/sectionvi/vi9pm.htm

Comment 4
13 CSR 30-7.010 Administrative Hearings

Update absent parent verbiage, update ACSE, change definition of client, define representative, define communicate, check on accuracy on actual process. Do we still use AOEO? Update AFDC verbage, more info on abatement. Does it need a complete rewrite?

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 30-7.010. FSD agrees the identified terminology needed to be updated and these changes have been considered in the current drafting process for this rule. In addition, the draft amendment not only updates terminology but also updates the hearing process set forth in the regulations.

Comment 5
13 CSR 30-8.010 Cooperation Agreement

Should this apply to more than just establishments? Include AGO as an entity to cooperate with. Client needs to complete a 509A – make this a requirement. Need more information on personal payments.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 30-8.010. DSS appreciates your comments and took them into consideration in the drafting process for the proposed amendment to this rule.

Comment 6
13 CSR 35-30.010 Voluntary Placement Agreement Solely for the Purpose of Accessing Mental Health Services and Treatment for Children Under Age Eighteen (18)

VPA takes 6-18 months for DMH to make a decision. Most of the time the children are found by DMH do not qualify. The rule needs to be amended to shorten the time for DMH to respond and to provide services to children/families during the evaluation period.

Response:

Thank you for submitting comments for the Children's Division (CD) regulation 13 CSR 35-30.010. This regulation outlines the procedure for utilizing a Voluntary Placement Agreement. It requires CD and the Department of Mental Health (DMH) to develop a protocol and policy for implementation of the program. The specific details of that protocol are not included in the regulation but specific time frames for response are outlined in the protocol, which was updated in 2015. The Department of Mental Health has three (3) days to respond to a referral by completing an assessment and making a recommendation. Your suggestions for improvement have been shared with the appropriate CD Central Office staff and meetings have been established with DMH personnel to determine if a better solution can be created to help children with acute needs.

Comment 7

13 CSR 35-31.020 Screening and Classification of Child Abuse/Neglect Hotline Reports

(3) states, "In all cases, the division must have face-to-face contact with all children in the alleged victim's household within seventy-two (72) hours." This rule is not being practiced in a consistent manner around the state. There are occasions in at least one area where Children's Division do not make face to face contract with all children in the alleged victim's household and there are also times when face to face contact is not made with the alleged victim. While we understand the need for county offices and circuits to institute practices that meet the needs of their communities, we believe fundamental rules that impact the safety of children should be carried out consistently around that state.

Response:

Thank you for submitting comments regarding the Children's Division (CD) regulation 13 CSR 35-31.020. Your concerns regarding inconsistency in following the 72 hour face-to-face regulation were shared with CD Central Office staff for appropriate handling. There may be specific reasons which impact the worker's ability to observe a child within seventy-two (72) hours, such as being unable to locate the family, but all reports are reviewed by a supervisor, who would not approve a report if the children were not seen, unless a verifiable exception applied, or if adequate efforts were not made. Please contact the Circuit Manager for your local Children's Division or Central Office if you have concerns about a particular case or practice.

Comment 8

13 CSR 35-31.020 Screening and Classification of Child Abuse/Neglect Hotline Reports

CD may decide the child does not need to be seen (in some areas – Springfield) does not go out ever.

(3) states, "In all cases, the division must have face-to-face contact with all children in the alleged victim's household within seventy-two (72) hours." This rule is not being practiced in a consistent manner around the state. There are occasions in at least one area where Children's Division do not make face to face contract with all children in the alleged victim's household and there are also times when face to face contact is not made with the alleged victim. While we understand the need for county offices and circuits to institute practices that meet the needs of their communities, we believe fundamental rules that impact the safety of children should be carried out consistently around that state.

(6) regarding response priority:

This section of the rule states, "Face-to-face contact can be made by members of the multidisciplinary team (mandated reporters such as juvenile officer, or law enforcement personnel)."

This statement is not clear and does not define who the members of the multidisciplinary team are intended to be. Is MDT in this statement to be interpreted as the Children's Division worker, law enforcement, and juvenile officers only or is MDT in this statement intended to include medical, mental health, child advocate, etc. Mandated reporters may include the school nurse, school bus driver, or a dentist. Are these mandated reporters appropriate to make face-to-face contact as required by this section of the rule?

Response:

Thank you for submitting comments regarding the Children's Division (CD) regulation 13 CSR 35-31.020. Your concerns regarding inconsistency in following the 72 hour face-to-face regulation have been shared with CD Central Office staff for appropriate handling. Specific contact was made with the Circuit Manager in Greene County to inquire about local practice. If you have a concern about a specific case or practice, please contact the local Circuit Manager, or Central Office staff, directly.

Your suggestion for clarification regarding the definition of "multidisciplinary team" is appreciated. Multidisciplinary teams are defined in law at Section 210.145.11, RSMo. The definition does not include all mandated reporters. MDT members and mandated reporters are separate, but linked, ideas. All MDT members are likely mandated reporters but all mandated reporters are not MDT members. By retaining the broad statutory definition, circuits have the ability to utilize local resources which may be unique to their area.

Comment 9

13 CSR 35-31.020 Screening and Classification of Child Abuse/Neglect Hotline Reports

(3) states, "In all cases, the division must have face-to-face contact with all children in the alleged victim's household within seventy-two (72) hours."

This rule is not being practiced in a consistent manner around the state, particularly in the rural counties where distances are great and resources are

stretched thin. We understand that each county/circuit should have the ability to meet the needs of the community, but some consistency should exist across the board. In these cases, it is almost if not totally impossible for this rule to be met within the timeframe prescribed. More positions and support to the local county offices will help in this regard.

Response:

Thank you for submitting comments regarding the Children's Division (CD) regulation 13 CSR 35-31.020. Your concerns regarding inconsistency in following the 72 hour face-to-face regulation will be shared with CD Central Office staff for appropriate handling.

Comment 10

13 CSR 35-31.020 Screening and Classification of Child Abuse/Neglect Hotline Reports

(3) states, "In all cases, the division must have face-to-face contact with all children in the alleged victim's household within seventy-two (72) hours."

This rule is not being practiced in a consistent manner around the state. There are occasions in at least one area where Children's Division do not make face to face contract with all children in the alleged victim's household and there are also times when face to face contact is not made with the alleged victim. While we understand the need for county offices and circuits to institute practices that meet the needs of their communities, we believe fundamental rules that impact the safety of children should be carried out consistently around that state.

(6) regarding response priority:

This section of the rule states, "Face-to-face contact can be made by members of the multidisciplinary team (mandated reporters such as juvenile officer, or law enforcement personnel)."

This statement is not clear and does not define who the members of the multidisciplinary team are intended to be. Is MDT in this statement to be interpreted as the Children's Division worker, law enforcement, and juvenile officers only or is MDT in this statement intended to include medical, mental health, child advocate, etc. Mandated reporters may include the school nurse, school bus driver, or a dentist. Are these mandated reporters appropriate to make the face-to-face contact as required by this section of the rule?

Response:

Thank you for submitting comments regarding the Children's Division (CD) regulation 13 CSR 35-31.020. Your concerns regarding inconsistency in following the 72 hour face-to-face regulation will be shared with CD Central Office staff for appropriate handling.

Your suggestion for clarification regarding the definition of "multidisciplinary team" is appreciated and will be taken into consideration for revision.

Comment 11

13 CSR 35-31.025 Child Abuse and Neglect Review Process

The alleged perpetrator will have 60 days from receipt of notification to request an administrative review. This regulation needs to be strictly enforced by circuit managers.

Response:

Thank you for commenting on the Children's Division regulation 13 CSR 35-31.025. This regulation states that the alleged perpetrator will have sixty days from the receipt of the notification of the child abuse/neglect finding to request an administrative review in writing to the circuit manager. This time frame is required per statute--§210.152, RSMo.

The sixty day time period begins the date the alleged perpetrator receives the CS-21 Disposition Letter or within 60 days from the resolution of pending criminal charges. *Pitts v. Williams,* 315 S.W.3d 755 (Mo. App. 2010) established guidelines around when the Division can proceed with an administrative review and when to release investigative records to the alleged perpetrator. Circuit Managers must follow guidelines established in this court decision, which may fall outside the 60 days.

Also, alleged perpetrators have due process rights per state law. If the Division cannot prove the alleged perpetrator received notice of the conclusion, the 60 day time frame may start over.

Comment 12

13 CSR 35-31.025 Child Abuse and Neglect Review Process

(2) (C) "The circuit manager, or his or her designee, will notify the alleged perpetrator in writing of the decision to uphold or reverse the original finding. <u>If the finding is upheld, the circuit manager, or his or her designee, will forward the request to the Child Abuse and Neglect Review Board (CANRB) for further administrative review."</u>

When a circuit manager makes a decision to uphold a finding, the burden of appealing the circuit manager's decision to the CANRB should be on the perpetrator not the circuit manager. This rule makes appealing a decision automatic and easy for the perpetrator. Children don't get the luxury of an automatic appeal when findings are not upheld.

An additional section should be added between 13 CSR 35-31.025 (6) and (7). This new section should require CANRB members participate in 8 hours of pre-service basic training about child abuse including the dynamics of child abuse, including definitions of abuse, indicators of abuse, normal sexual behaviors and inappropriate sexual behaviors, child development, anatomical language, and grooming behaviors of sexual abusers, the process of children disclosing child abuse, and the dynamics of coercive control.

(9) (A) 3 "If requested, and not otherwise prohibited by statute, <u>the circuit manager will provide a copy of the child abuse and neglect investigation to the alleged perpetrator,</u> including all records provided to the board, with the exception of confidential information or other information that could jeopardize child safety."

This rule needs to be deleted or made consistent with RSMo. 510.035. "…any visual or aural recordings or photographs of a minor who is alleged to be the victim

of an offense under chapter 566 created by or in the possession of child assessment center, health care provider, or multidisciplinary team member shall not be copied or distributed to any 5 person or entity, unless required by supreme court rule 25.03 or if a court orders such 6 copying or distribution upon a showing of good cause after notice and a hearing an after 7 considering the safety and privacy interests of any victim"

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 35-31.025. In the Administrative Review phase of the appeal process, the Circuit Manager will forward the alleged perpetrator's appeal to the Child Abuse and Neglect Review Board (CANRB) to implement the due process appeal rights of that individual. This requirement is the result of *Jamison v. Dep't of Soc. Servs., Div. of Family Servs.,* 218 S.W.3d 399 (Mo. 2007), and, therefore, cannot be revised.

Training is provided annually to CANRB members and is not outlined in the regulation. Your suggestion to include specific training requirements in the regulation will be shared with Children's Division Central Office staff for consideration.

Also, your suggestion to revise 13 CSR 35-31.025(9)(A)3 to reflect a change in statute is appreciated and will be shared with Central Office staff for appropriate consideration in the drafting of any amendment to this rule.

Comment 13

13 CSR 35-31.025 Child Abuse and Neglect Review Process

(2)(C)Case law is the reason we send on to CANRB (2) (C) "The circuit manager, or his or her designee, will notify the alleged perpetrator in writing of the decision to uphold or reverse the original finding. <u>If the finding is upheld, the circuit manager, or his or her designee, will forward the request to the Child Abuse and Neglect Review Board (CANRB) for further administrative review.</u>"

When a circuit manager makes a decision to uphold a finding, the burden of appealing the circuit manager's decision to the CANRB should be on the perpetrator not the circuit manager. This rule makes appealing a decision automatic and easy for the perpetrator. Children don't get the luxury of an automatic appeal when findings are not upheld.

An additional section should be added between 13 CSR 35-31.025 (6) and (7). This new section should require CANRB members participate in 8 hours of pre-service basic training about child abuse including the dynamics of child abuse, including definitions of abuse, indicators of abuse, normal sexual behaviors and inappropriate sexual behaviors, child development, anatomical language, and grooming behaviors of sexual abusers, the process of children disclosing child abuse, and the dynamics of coercive control.

(9) (A) 3 "If requested, and not otherwise prohibited by statute, <u>the circuit manager will provide a copy of the child abuse and neglect investigation to the alleged perpetrator,</u> including all records provided to the board, with the exception of confidential information or other information that could jeopardize child safety."

This rule needs to be deleted or made consistent with RSMo. 510.035. "…any visual or aural recordings or photographs of a minor who is alleged to be the victim of an offense under chapter 566 created by or in the possession of child assessment center, health care provider, or multidisciplinary team member shall not be copied or distributed to any 5 person or entity, unless required by supreme court rule 25.03 or if a court orders such 6 copying or distribution upon a showing of good cause after notice and a hearing an after 7 considering the safety and privacy interests of any victim"

(13) "The board shall expunge its administrative files at three (3) years with the exception of a log documenting the boards final decision." Because the Missouri constitution now allows propensity evidence in sexual abuse cases, files should no longer be expunged.

(Missouri Constitution Article I, Bill of Rights, Section 18(c) "Notwithstanding the provisions of sections 17 and 18(c) of this article to the contrary, in prosecutions for crimes of a sexual nature involving a victim under eighteen years of age, relevant evidence of prior criminal acts, whether charged or uncharged, is admissible for the purpose of corroborating the victim's testimony or demonstrating the defendant's propensity to commit the crime with which he or she is presently charged. The court may exclude relevant evidence of prior criminal acts if the probative value of the evidence is substantially outweighed by the danger of unfair prejudice."

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 35-31.025. In the Administrative Review phase of the appeal process, the Circuit Manager will forward the alleged perpetrator's appeal to the Child Abuse and Neglect Review Board (CANRB) to implement the due process appeal rights of that individual. This requirement is the result of *Jamison v. Dep't of Soc. Servs., Div. of Family Servs.,* 218 S.W.3d 399 (Mo. 2007), and, therefore, cannot be revised.

Training is provided annually to CANRB members and is not outlined in the regulation. Your suggestion to include specific training requirements in the regulation will be shared with Children's Division Central Office staff for consideration.

Also, your suggestion to revise 13 CSR 35-31.025(9)(A)3 to reflect a change in statute is appreciated and will be shared with Central Office staff for appropriate consideration in the drafting of any amendment to this rule.

The regulation allows the CANRB to destroy "administrative files" after three years. These files would include date, time, location of the meeting, and other administrative information regarding the Board. Actual investigative case files are retained indefinitely in a preponderance of the evidence finding. Your suggestion will be reviewed to ensure the Children's Division is complying with the specific law.

Comment 14
13 CSR 35-31.025 Child Abuse and Neglect Review Process

(2) (C) "The circuit manager, or his or her designee, will notify the alleged perpetrator in writing of the decision to uphold or reverse the original finding. If the finding is upheld, the circuit manager, or his or her designee, will forward the request to the Child Abuse and Neglect Review Board (CANRB) for further administrative review."

If a circuit manager upholds a finding, the burden of appealing should be on the perpetrator and not the circuit manager. This seems backward.

CA/N Review Board Members should be required to attend training on the dynamics of child abuse. They should understand the difference between normal sexual behaviors and inappropriate sexual behaviors, the process of disclosure by children when it comes to abuse, grooming of children by perpetrators,

(9) (A) 3 "If requested, and not otherwise prohibited by statute, the circuit manager will provide a copy of the child abuse and neglect investigation to the alleged perpetrator, including all records provided to the board, with the exception of confidential information or other information that could jeopardize child safety."

This rule needs to be updated or made consistent with RSMo. 510.035; "…any visual or aural recordings or photographs of a minor who is alleged to be the victim of an offense under chapter 566 created by or in the possession of a child assessment center, health care provider, or multidisciplinary team member shall not be copied or distributed to any person or entity, unless required by supreme court rule 25.03 or if a court orders such 6 copying or distribution upon a showing of good cause after notice and a hearing and after 7 considering the safety and privacy interests of any victim."

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 35-31.025. In the Administrative Review phase of the appeal process, the Circuit Manager will forward the alleged perpetrator's appeal to the Child Abuse and Neglect Review Board (CANRB) to implement the due process appeal rights of that individual. This requirement is the result of *Jamison v. Dep't of Soc. Servs., Div. of Family Servs.,* 218 S.W.3d 399 (Mo. 2007), and, therefore, cannot be revised.

Training is provided annually to CANRB members and is not outlined in the regulation. Your suggestion to include specific training requirements in the regulation will be shared with Children's Division Central Office staff for consideration.

Also, your suggestion to revise 13 CSR 35-31.025(9)(A)3 to reflect a change in statute is appreciated and will be shared with Central Office staff for appropriate consideration in the drafting of any amendment to this rule.

Comment 15

13 CSR 35-31.025 Child Abuse and Neglect Review Process

(2) (C) "The circuit manager, or his or her designee, will notify the alleged perpetrator in writing of the decision to uphold or reverse the original finding. If the finding is upheld, the circuit manager, or his or her designee, will forward the

request to the Child Abuse and Neglect Review Board (CANRB) for further administrative review."

When a circuit manager makes a decision to uphold a finding, the burden of appealing the circuit manager's decision to the CANRB should be on the perpetrator, not the circuit manager. (So then what process are you suggesting?)This rule makes appealing a decision automatic and easy for the perpetrator. Children don't get the luxury of an automatic appeal when findings are not upheld.

Also, under (A) Section (H), # 3, It reads, "The Board's decision must be based on competent and substantial evidence on the whole record to support the preponderance of the evidence finding of abuse or neglect."

Having volunteered on a CAN Review board in the past, I can tell you that many times, cases are reversed on technicalities, rather than competent and substantial evidence! It happens regularly.

Through no fault of their own, CAN members have no training on many aspects of child abuse and neglect, perpetrators, etc. Even though they are volunteers, a minimum training should be expected so that they can make cogent decisions that are fair and equitable to all concerned.

An additional section should be added between 13 CSR35-31.025 (6) and (7). This new section should require CANRB members participate in 8 hours of pre-service basic training about child abuse including the dynamics of child abuse, including definitions of abuse, indicators of abuse, normal sexual behaviors and inappropriate sexual behaviors, child development, anatomical language, and grooming behaviors of sexual abusers, the process of children disclosing child abuse, and the dynamics of coercive control.

(9) (A) 3 "If requested, and not otherwise prohibited by statute, the circuit manager will provide a copy of the child abuse and neglect investigation to the alleged perpetrator, including all records provided to the board, with the exception of confidential information or other information that could jeopardize child safety."

This rule needs to be deleted or made consistent with a recently passed statute…. RSMo. 510.035. "…any visual or aural recordings or photographs of a minor who is alleged to be the victim of an offense under chapter 566 created by or in the possession of a child assessment center, health care provider, or multidisciplinary team member shall not be copied or distributed to any 5 person or entity, unless required by supreme court rule 25.03 or if a court orders such 6 copying or distribution upon a showing of good cause after notice and a hearing and after 7 considering the safety and privacy interests of any victim."

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Comment 16
13 CSR 35-31.025 Child Abuse and Neglect Review Process

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Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 35-31.025. In the Administrative Review phase of the appeal process, the Circuit Manager will forward the alleged perpetrator's appeal to the Child Abuse and Neglect Review Board (CANRB) to implement the due process appeal rights of that individual. This requirement is the result of *Jamison v. Dep't*

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Also, your suggestion to revise 13 CSR 35-31.025(9)(A)3 to reflect a change in statute is appreciated and will be shared with Central Office staff for appropriate consideration in the drafting of any amendment to this rule.

Comment 17
13 CSR 35-31.027 Juveniles with Problem Sexual Behaviors

3(C) makes participation in services voluntary. There needs to be sanctions for forcing the family/child to engage in their services. She would like to see a judge have the power to order services.

Response:

Thank you for submitting comments regarding Children's Division (CD) regulation 13 CSR 35-31.027. CD is authorized to receive reports regarding juveniles with problem sexual behaviors per §210.148, RSMo. The statute states CD should utilize a "family services and assessment approach" to respond to the allegations, which involves a voluntary participation in services. The statute also allows CD to initiate an investigation if necessary. CD staff also has the ability to refer any family to the local juvenile court, if the family does not voluntarily participate in services and there are concerns for safety of the victim child or other at-risk children.

Comment 18
13 CSR 35-31.027 Juveniles with Problem Sexual Behaviors

An additional section should be added between 13 CSR 35-31.027 (3) and (4) to clarify that Children's Division implement best practice and refer the victim of a juvenile with problem sexual behavior to child advocacy centers. In addition, Children's Division should implement best practice by referring the juvenile with problem sexual behaviors to the child advocacy center when there is a concern of the juvenile has disclosed their own victimization.

Response:

Thank you for submitting comments regarding the Children's Division (CD) regulation 13 CSR 35-31.027. The practice of referring both the victim child(ren) and the juvenile with the problem sexual behaviors to a Child Advocacy Center (CAC) is an internal process. Consideration for referrals to the CAC are outlined in CD's Child Welfare Manual in Chapter 10 entitled Juveniles with Problem Sexual Behaviors and is available at the following link: http://dss.mo.gov/cd/info/cwmanual/section2/ch10/sec2ch10index.htm#n10318.
Alleged child initiators of problem sexual behaviors with their own history of victimization is a reason to refer them to the CAC. Referring to a CAC is a policy and protocol issue addressed on a statewide level to develop a consistent response

and the appropriate CD personnel are working with local CACs to develop revised language for this specific issue to insert into the protocols.

Comment 19
13 CSR 35-31.027 Juveniles with Problem Sexual Behaviors

An additional section should be added between 13 CSR 35-31.027 (3) and (4) to clarify that Children's Division implement best practice and refer the victim of a juvenile with problem sexual behavior to child advocacy centers. In addition, Children's Division should implement best practice by referring the juvenile with problem sexual behaviors to the child advocacy center when there is a concern of the juvenile has disclosed their own victimization.

Response:

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Comment 20
13 CSR 35-31.027 Juveniles with Problem Sexual Behaviors

Need to clarify that Children's Division implement best practice and refer the victim of a juvenile with problem sexual behaviors to a child advocacy center. The juvenile with problem sexual behaviors should be referred to the child advocacy center when there is a concern or a disclosure by the juvenile of their own victimization.

Response:

Thank you for submitting comments regarding the Children's Division (CD) regulation 13 CSR 35-31.027. The practice of referring both the victim child(ren) and the juvenile with the problem sexual behaviors to a Child Advocacy Center (CAC) is an internal process. Consideration for referrals to the CAC are outlined in CD's Child Welfare Manual in Chapter 10 entitled Juveniles with Problem Sexual Behaviors and is available at the following link: http://dss.mo.gov/cd/info/cwmanual/section2/ch10/sec2ch10index.htm#n10318.
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13 CSR 35-31.027 Juveniles with Problem Sexual Behaviors

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Response:

Thank you for submitting comments regarding the Children's Division (CD) regulation 13 CSR 35-31.027. The practice of referring both the victim child(ren) and the juvenile with the problem sexual behaviors to a Child Advocacy Center (CAC) is an internal process. Consideration for referrals to the CAC are outlined in CD's Child Welfare Manual in Chapter 10 entitled Juveniles with Problem Sexual Behaviors and is available at the following link: http://dss.mo.gov/cd/info/cwmanual/section2/ch10/sec2ch10index.htm#n10318.
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13 CSR 35-31.027 Juveniles with Problem Sexual Behaviors

An additional section should be added between 13 CSR 35-31.027 (3) and (4) to clarify that Children's Division implement best practice and refer the victim of a juvenile with problem sexual behaviors to child advocacy centers. In addition, Children's Division should implement best practice by referring the juvenile with problem sexual behaviors to the child advocacy center when there is a concern or the juvenile has disclosed their own victimization.

Response:

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Alleged child initiators of problem sexual behaviors with their own history of victimization is a reason to refer them to the CAC. Referring to a CAC is a policy and protocol issue addressed on a statewide level to develop a consistent response and the appropriate CD personnel are working with local CACs to develop revised language for this specific issue to insert into the protocols.

Comment 23
13 CSR 35-31.027 Juveniles with Problem Sexual Behaviors

These reports should be expunged when children turn 18 or immediately when there are no concerns. These reports should not be held over a child's head for the rest of their lives. Juvenile offenses that are through the court are expunged but these are not. These are just allegations that anyone can make for any reason without cause but we take them as fact and hang them over people's heads for the rest of their lives and claim that it is for the child's best interest. If there are no concerns why keep the report?

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 35-31.027. The Juvenile with Problem Sexual Behavior reports are required under state statute §210.148, RSMo to follow a "family services and assessment" approach as outlined in §210.145, RSMo. Family assessment identifying information is retained indefinitely per §210.152, RSMo. Therefore, the change in the retention schedule would require a statutory revision.

Although the Children's Division cannot revise a regulation in violation of state law, your suggestion will be shared with appropriate Children's Division Central Office staff. We encourage you to contact your local legislators to share your concerns regarding this law.

Comment 24
13 CSR 35-32.010 Basis of Payment

The department should insert (8) to require anyone receiving payments for child care services should be required to document participation in biennual training in mandatory reporting of child abuse to include at a minimum:

1) Legal requirements of mandated reporters
2) Indicators of child abuse and neglect
3) Responding to suspicions, discovery of disclosure of child abuse and neglect
4) Effectively reporting child abuse and neglect

By requiring child care providers to participate in mandatory reporting training, the Department is setting the expectation for the service provider to create a safe environment for children.

Response:

Thank you for submitting comments on the Children's Division regulation 13 CSR 35-32.010. A revision to Title 13 Division 35 Chapter 32 Child Care was pending at the time your comment was received in August 2017 and 13 CSR 35-32.010 was rescinded, effective August 30, 2017. The revised Child Care regulations have been promulgated and are now available on the Secretary of State website: https://www.sos.mo.gov/cmsimages/adrules/csr/current/13csr/13c35-32.pdf. These new regulations state that child care providers are required to complete child abuse and neglect mandated reporter training prior to receiving a contract with the Children's Division for payment of child care subsidy.

If you would like to receive email updates from the Children's Division Early Childhood and Prevention Services Section, please send an email to

CD.ASKECPS@dss.mo.gov and request to be added to our email distribution list. Please indicate if you are licensed or license exempt. Additional information on Early Childhood and Child Care Subsidy may be found at https://dss.mo.gov/cd/child-care/.

Comment 25
13 CSR 35-32.020 Foster Care Case Management Contracts

Kelly oversees a residential treatment facility – Ashley House. She previously worked for the state. Foster Care Case Management (FCCM) regulations: New contracts were issued 1 ½ years ago. It reduced half of workforce (all FCCM) in Springfield. In Joplin more FCCM slots were allocated. FCCM was doing well in Springfield and poorly in Joplin. This was not beneficial to families; it was devastating. Is there a better way to renew contracts and numbers/allocations? Other FCCM agencies don't do well and there is a lot of turnover. Do the right people know when there are concerns with a contractor? There is poor communication surrounding the FCCM contracts – i.e. renewals; awards. It is not handled well by the state. There needs to be better communication to help FCCM understand what is going on. Foster Parent rates were cut and given back. She heard the cut is coming out of service dollars – is that accurate? Residential treatment concerns: transitional rates are very low and providers can't cover the costs. There is inconsistency among juvenile judges; it is ridiculous. The Office of Child Advocate review in Newton County stated there is not adequate oversight for Judges. There is nowhere to go if something needs to be grieved.

Response:

Thank you for sharing comments regarding the Children's Division (CD) regulation 13 CSR 35-32.020. The proposed rate decrease for foster care maintenance was reinstated by the Governor in July, 2017. The reinstatement occurred before any rates were actually reduced.

Section 210.112, RSMo, requires the CD to contract with community providers for case management services through a competitive bid process. Foster Care Case Management (FCCM) contracts are awarded through this process. Your concerns regarding the FCCM contracts and communication by CD will be shared with Children's Division Central Office staff to address as appropriate.

CD meets regularly to review performance outcome data and data on the growth and decline of the foster care population in all 46 circuits, which includes the circuits that hold the FCCM contract. We also meet quarterly with FCCM CEO's and separately with FCCM Program Managers to discuss program improvement and quality assurance among other topics as well. The information gathered as a result of these efforts helps inform the contracting process. The decisions made about where the contract is offered and about allocations for the contract are determined by this rigorous collaborative and data informed process, as well as the budget approved by the Legislature/ Governor each year. There is a formal quality improvement process that provides consumers or anyone with concerns about an FCCM agencies' performance a pathway to communicate that concern and receive feedback regarding any remedies.

Turnover unfortunately is a byproduct of working in the challenging field of Child Welfare and not unique to our FCCM partners. CD also struggles with turnover and the impact it has on consistency in case management and service provision for families and children. Reducing turnover and improving staff recruitment and retention are areas that FCCM and CD are actively working to improve. Many changes have been implemented already with efforts underway to assess the impact of those changes on our child welfare workforce.

CD prepares a General Assembly Report every July that informs the MO Legislature about the outcomes achieved by having the FCCM contract in certain circuits around the state. This information is available to the public as well.

Comment 26
13 CSR 35-32.020 Foster Care Case Management Contracts

The Department should insert an additional requirement after (1) to require contactors, their officers, agents, employees, volunteers and subcontractors to institute codes of conduct to include at a minimum:

1) Screening and selecting employees and volunteers
2) Guidelines on interactions between individuals
3) Monitoring behavior
4) Ensuring safe environments
5) Responding to inappropriate behavior, breaches in policy, and allegations and suspicions of child sexual abuse
6) Training for employees and volunteers about child abuse including sexual abuse

(6) add 10. To require biennual training on mandatory reporting of child abuse that includes at a minimum:

1) Legal requirements of mandated reporters
2) Indicators of child abuse and neglect
3) Responding to suspicions, discovery or disclosure of child abuse and neglect
4) Effectively reporting child abuse and neglect

The Department should require any contractor for any services provided to youth or on behalf of youth should require codes of biennual mandatory training.

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 35-32.020. The Foster Care Case Management (FCCM) contracts contain more detailed requirements regarding staff code of conduct and specific training. Most of your suggestions are required in the current contracts.

Your suggestions, however, will be shared with Children's Division Central Office staff for consideration in future contracts.

Comment 27
13 CSR 35-32.020 Foster Care Case Management Contracts

The Department should insert an additional requirement after (1) to require contactors, their officers, agents, employees, volunteers and subcontractors to institute codes of conduct to include at a minimum:

7) Screening and selecting employees and volunteers
8) Guidelines on interactions between individuals
9) Monitoring behavior
10) Ensuring safe environments
11) Responding to inappropriate behavior, breaches in policy, and allegations and suspicions of child sexual abuse
12) Training for employees and volunteers about child abuse including sexual abuse

(6) add 10. To require biennual training on mandatory reporting of child abuse that includes at a minimum:

5) Legal requirements of mandated reporters
6) Indicators of child abuse and neglect
7) Responding to suspicions, discovery or disclosure of child abuse and neglect
8) Effectively reporting child abuse and neglect

The Department should require any contractor for any services provided to youth or on behalf of youth should require codes of biennual mandatory training.

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 35-32.020. The Foster Care Case Management (FCCM) contracts contain more detailed requirements regarding staff code of conduct and specific training. Most of your suggestions are required in the current contracts.

Your suggestions, however, will be shared with Children's Division Central Office staff for consideration in future contracts.

Comment 28

13 CSR 35-32.020 Foster Care Case Management Contracts

Consider inserting requirements for training for contractors, their officers, agents, employees, volunteers and subcontractors to institute codes of conduct that include:

a. Screening and selecting employees and volunteers
b. Guidelines on interactions between individuals
c. Monitoring behavior
d. Ensuring safe environments
e. Responding to inappropriate behavior, breaches in policy, and allegations and suspicions of child sexual abuse

Training for employees and volunteers about child sexual abuse

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 35-32.020. The Foster Care Case Management (FCCM) contracts contain more detailed requirements regarding staff code of conduct and specific training. Most of your suggestions are required in the current contracts.

Your suggestions, however, will be shared with Children's Division Central Office staff for consideration in future contracts.

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13 CSR 35-32.020 Foster Care Case Management Contracts

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4) Ensuring safe environments
5) Responding to inappropriate behavior, breaches in policy, and allegations and suspicions of child sexual abuse
6) Training for employees and volunteers about child abuse including sexual abuse

(6) add 10. To require biennual training on mandatory reporting of child abuse that includes at a minimum:

1) Legal requirements of mandated reporters
2) Indicators of child abuse and neglect
3) Responding to suspicions, discovery or disclosure of child abuse and neglect
4) Effectively reporting child abuse and neglect

The Department should require any contractor for any services provided to youth or on behalf of youth should require codes of conduct and biennual mandatory reporting training.

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 35-32.020. The Foster Care Case Management (FCCM) contracts contain more detailed requirements regarding staff code of conduct and specific training. Most of your suggestions are required in the current contracts.

Your suggestions, however, will be shared with Children's Division Central Office staff for consideration in future contracts.

Comment 30

13 CSR 35-32.090 Registration Requirements for Licensed Child Care Facilities to Contract for State or Federal Child Care Funds

Are there any funds to assist with fingerprinting? The YMCA supports and can advocate for funds, if needed. Illinois pays for fingerprinting; Missouri should consider this. The requirement to get CPR and First Aid training in 30 days is not realistic. Can this time frame be expanded? The retention of records is for five years or "other time frame". Can it be more definitive? (Explained need to retain records for audit or legal purposes)

Response:

Thank you for providing comments regarding the Children's Division regulation 13 CSR 35-32.090. Registration requirements for licensed child care facilities to contract for state or federal child care funds allows up to 90 days for new staff to

receive the required training; including First Aid and CPR. Child care staff have a full state fiscal year to complete the required annual training.

The regulation states records should be retained for five years or "other time frames." All records should be retained for a minimum of five years. In certain circumstances, such as an audit or legal issue, records may need to be retained for a longer period of time. If so, the child care provider would be made aware of the requirement to retain records longer than five years.

Your other comments and suggestions will be shared with Children's Division Central Office staff for consideration.

If you would like to receive email updates from the Children's Division Early Childhood and Prevention Services Section, please send an email to CD.ASKECPS@dss.mo.gov and request your name be added to our email distribution list. Please indicate if you are licensed or license exempt.

Comment 31
13 CSR 35-50.010 Licensing

Division 35, Chapter 50 general comments: This rule was promulgated following the passage of a bill impacting RsMO 210.481 through 210.511 during 2014. Specifically, an agency accredited by Council on Accreditation of Services for Children and Families, Inc (COA); The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF), after the initial license simplified future action by the Department of Social Services.

This rule is clear. The challenge the rule continues to face is that the regulators (Children's Division) continue to overstep the requirement of the statute or rule, by continuing business as usual. Great Circle has clear examples of the overreach by Children's Division beyond the rule requirements, often citing routine and previous practice as rational for the overreach

Recommendation for Action:

1. Fully implement Chapter 50 Rule.
2. Build on the private agencies impacted by this rule to develop a best practice documentation for implement.
3. Recognize that this rule impacts both residential treatment and child placing agency licenses issued by the Children's Division, Department of Social Services.

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 35-50.010. You are correct, state statute and the regulation both state accreditation by those facilities is evidence the agency meets licensing requirements. Your concerns and suggestions regarding the Children's Division handling of these licensed agencies will be shared with CD Central Office staff for review and appropriate handling.

Comment 32
13 CSR 35-60.020 Capacity of Foster Homes

The limit of 5 children total per home is arbitrary and hinders the ability of caseworkers and the state to place children in loving homes, rather than in group homes or other residential facilities. Personally, I am aware of many families who would welcome additional foster children into their home, however are not able to do so due to the 5 children limit. I would recommend that the 5 children total NOT include biological or previously adopted children but ONLY apply the limit to foster children in the home. We are in the process of finalizing adoptions on the 5 children currently placed with us. Once that finalization is complete, we will no longer be permitted to keep our license open and accept other placements. We have the room - both figuratively and literally - for at least one more child (if not more). The state already struggles to have enough foster parents for the children in their care - it seems silly and arbitrary to limit the services of those willing to serve in this capacity. When this law changed, it forced many homes to close their license. It further complicated the need for foster homes by limiting the number of children in a home. As with many laws that change with regards to the childrens division, the workers and even supervisors and managers do not clearly understand the law. When this law changed there were many workers moving children from current foster homes to other homes to get them at five children or less. This law wording does mention a waiver for children in sibling groups. The relative law states that the number of children in the home can be waived for relative care. This law does not state for the placement of sibling groups, but workers, supervisors and managers are confused by this. Because of this, we had a family member that was bonded to us, not allowed to be placed with us and instead placed two counties away. The law states that the number of children in the home is limited to five. It does not state that step children that visit the homebon an occasional basis (four overnights a month) must be counted, but in our case we were forced to close our license due to this. There has been so much confusion, at least in our district, with understanding the law. When we were licensed for foster parents our children that did not live with us were not counted in our numbers. With the law being six children, we had five foster children. We were asked to take a sibling group of 5. That left us with ten foster children. We have a large home with five bedrooms and had the room. Shortly after placement it was decided they would move part of the sibling group, but not because of our ability to have ten, but because of the numbers. Three siblings were moved. When one of our other placements of two went home, one of the siblings returned. We now have three children in our five bedroom home but were forced to close our license because we have two children that live with their other parent and only visit occasionally. They are teenagers. Also, due to not understanding the law we had other issues. We were primarily interested in infant placements. We tried to always have an empty spot for infants, but were willing to accept older children. We were overlooked many times for infant placements. When questioned it was told to us that one of the reasons was that the other families had a stay at home parent. I actually quit my job of ten years in public health to be able to stay home and be a stay at home parent.

Response:

Thank you for submitting comments the Children's Division regulation 13 CSR 35-60.020. The Children's Division is required by law to be accredited through the Council on Accreditation (COA) as outlined in §210.113, RSMo. In order to maintain accreditation, the Children's Division has followed the best practice guidelines for capacity provided by COA which states resource homes should have no more than five children, with no more than two children under the age of 2, and no more than two children in treatment foster care.

The Children's Division does have the authority to make placements above the capacity for placement of sibling groups and minor parents and their child(ren).

Your concerns regarding Children's Division staff who do not understand the capacity regulations will be shared with Children's Division Central Office staff to address as appropriate.

Comment 33
13 CSR 35-60.020 Capacity of Foster Homes

I was watching a couple children in my home, but had many inquiries about childcare. I researched the possibility of getting licensed for childcare. The law states that a dually licensed foster/ childcare home can not have children under 7 in foster care. This law is absurd. When I questioned this law, our licensing worker submitted a letter to our childcare licensing worker that stated we were allowed to. During the process of getting licensed for childcare, I signed a contract with Head Start as a Family Childcare Partner. I made costly modifications to my home and was able tp get licensed. A week after getting licensed I received a letter stating we could not have foster children under the age of 7, but they were not moving our adoptive placement that was under 7. All of this could have been avoided if there was a better understanding of the law.

Response:

Thank you for your comments regarding the Children's Division regulation 13 CSR 35-60.020(6). This regulation states if a licensed foster parent is dually licensed as a child care provider, no child under the age of seven may be placed in the home unless necessary to accommodate a sibling group.

Your concern regarding staff not understanding the law will be shared with appropriate Children's Division staff in Central Office for appropriate handling or training.

Comment 34
13 CSR 35-60.020 Capacity of Foster Homes

Debbie is a foster parent and licensed through Mo Alliance for Children and Families, a Foster Care Case Management (FCCM) contractor. She has a lot of placements from Jefferson County. Debbie has heard there is a pending licensing category for large family group home. Her worker says she doesn't know about this program or how to get training. Some homes can handle more than five children. Sibling groups are sometimes split if there is a teenager and the foster parent doesn't want a teenager. When Debbie has a bed available, the information isn't

shared with CD. CD & FCCM need a better system of tracking open placement/beds.

Response:

Thank you for submitting comments on the Children's Division regulation 13 CSR 35-60.020. The Children's Division is required by law to be accredited through the Council on Accreditation (COA) as outlined in §210.113, RSMo. In order to maintain accreditation, the Children's Division has followed the best practice guidelines for capacity provided by COA which states resource homes should have no more than five children, with no more than two children under the age of 2, and no more than two children in treatment foster care.

The Children's Division does have the authority to make placements above the capacity for placement of sibling groups and minor parents and their child(ren).

Your concerns regarding contracted staff who do not understand the capacity regulations will be shared with Children's Division Central Office staff to address as appropriate.

Thank you for your continued service as a foster parent to Missouri's children.

Comment 35

13 CSR 35-60.020 Capacity of Foster Homes

Phyllis served on the Recruitment and Retention Task Force. St. Louis County will go over capacity in a foster home with an exception letter. However, it is not clear regarding siblings. If CD or a contracted agency wants to place a child in your foster home that will make you go over capacity, it is ok. If the foster parent wants to take additional child that will put the home over capacity, it is not always approved. CD should know your capabilities. This has not personally happened to her, but to other foster parents. Licensing staff should know a foster parent's capabilities. Can CD ask for an exception with COA to exceed capacity? For example, allow a foster parent to exceed capacity for teenagers to avoid residential treatment?

She has a foster child in college who received an ILA payment. Over the summer the child didn't get the ILA payment and the foster parent received no maintenance.

A foster parent can't change plans for Medicaid; it has to be a CD worker. Can this be fixed?

Response:

Thank you for submitting comments on the Children's Division regulation 13 CSR 35-60.020. The Children's Division is required by law to be accredited through the Council on Accreditation (COA) as outlined in §210.113, RSMo. In order to maintain accreditation, the Children's Division has followed the best practice guidelines for capacity provided by COA which states resource homes should have no more than five children, with no more than two children under the age of 2, and no more than two children in treatment foster care.

The Children's Division does have the authority to make placements above the capacity for placement of sibling groups and minor parents and their child(ren).

Your additional concerns/comments will be shared with Children's Division Central Office staff to address as appropriate.

Thank you for your continued service as a foster parent to Missouri's children.

Comment 36
13 CSR 35-60.020 Capacity of Foster Homes

There is a rule that a licensed daycare owner who takes Foster Children into their home can not get state assistance for child care paid to them.

I am proposing that rule should be taken off. To understand my reasoning, I'm going to explain what our situation was like when we became foster parents.

I own a daycare center in Hallsville, Mo called Little Indians Preschool. We are always at full capacity with about a two year waiting list for new children. There is a foster family in Hallsville that often takes children in. I try to keep a couple spots open for them so when they get new kids, they can bring them to me for daycare. Foster care has always been where my heart is and I feel Little Indians is the perfect place for a foster child to come. This foster family said yes to what turned out to be a family of 5 children all under the age of 6. I made room here at the preschool and the state was of course paying me their daycare. They thought the kids would only be there for a short period but as time went on, they knew these kids would be in the foster system for a while. They were not going to be able to keep them long term. We had fallen in love with these kids here so I called their caseworker and told her my family wanted to foster them. Long story short, within in month they came to live with us. We were licensed as kinship foster parents. I was told before we took them in that I could no longer receive the state daycare payments for them. This was not an issue for us because financially we could make that cut work. So we fostered this family for two years before adopting them a year ago!

The problem I have with this rule is the State Licensing daycare rules state that we have to include our foster children in our teacher/child ratios. So I had to count these 5 children in my numbers for the daycare licensing. This caused me to lose payment for 5 of those spots. Again, I knew this going into it and my family was able to take this cut in income but most daycare owners would not be able to do this. What also bothers me about this rule is that I could have taken the kids to another daycare in Hallsville and the state would pay them, but just because I was keeping them with me, there daycare was not paid. In my opinion what better place for foster children to be during the day, then with their foster Mom. My teachers knew these kids so well and knew their behavior issues and how to deal with them. I was there to help the teachers and kids when problems or questions arose. All their friends were there and the other parents were so supportive of us! I was not about to take my biological kids with me to my preschool but drop my foster children off at another daycare.

We did go through the appeal process but we were denied any changes. Everyone at the appeal was in agreement that I should get paid for their daycare but it just kept coming back to "policy states". So no one could go against what the policy stated. I remember even at one point when I asked what I could do to change the

policy then, someone said "Write the Governor" I never did so I figured this was the perfect opportunity :)

I know this policy is probably there to prevent fraud or people from just becoming foster parents to get daycare payment. However my opinion is what better foster parent then a licensed daycare owner. It takes a lot to get a licensed daycare even if you are doing it inside your home. Most daycare owners have such a heart for kids or they wouldn't be doing what they are doing. They are providing a safe fun loving nurturing place where other people pay to bring their children too. Why would the state not want them to keep their foster children with them during the day?

This would no longer benefit me in anyway because once we were able to adopt this sibling group, I no longer have to count them in my daycare numbers but I'm truly passionate about this topic. This policy never made sense to me from the beginning and at the appeal, it didn't make sense to anyone there either. So, I would appreciate you considering removing this policy. If you have any questions, please feel free to email me or call me at 573-864-0155. Thank you for your time.

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 35-60.020. Resource parents are standing *in loco parentis* and are not allowed to provide registered or licensed child care to their own children including any foster child(ren) placed in their home. In order for a person to be considered *in loco parentis,* he or she must have intentionally assumed the rights and duties of a parent. Child care providers cannot receive subsidy payment for their own children.

Your comments and concerns regarding this regulation will be shared with Children's Division Central Office staff for consideration. Thank you for your continued service as a foster parent to Missouri's children.

Comment 37

13 CSR 35-60.030 Minimum Qualifications of Foster Parents

(3) The Department should insert an additional requirement after (C) to require foster parents to institute codes of conduct for themselves, their family and foster children to include at a minimum:

1) Guidelines on interactions between individuals
2) Monitoring behavior
3) Ensuring safe environments
4) Responding to inappropriate behavior, breaches in policy, and allegations and suspicions of child abuse

(5) The Department should insert a new (B) to require pre-service education and then biennial training on mandatory reporting of child abuse that includes at a minimum:

1) Legal requirements of mandated reporters
2) Indicators of child abuse and neglect
3) Responding to suspicions, discovery or disclosure of child abuse and neglect

4) Effectively reporting child abuse and neglect

In service training should also require foster parents to received training in the protective factors that includes at a minimum concrete support in times of need for parents, knowledge of parenting and child development, social connections, parental resilience, and social and emotional development of children.

Response:

Thank you for submitting comments regarding the Children's Division (CD) regulation 13 CSR 35-60.30. The Foster Home Licensing regulations outline basic requirements for training, such as pre-service and in-service training. CD does not typically include specific training requirements in regulation as these may change more frequently. Specific training requirements are outlined in the foster parent training curriculums. Your suggested revisions will be shared with appropriate CD Central Office staff for consideration.

Comment 38

13 CSR 35-60.030 Minimum Qualifications of Foster Parents

(3) The Department should insert an additional requirement after (C) to require foster parents to institute codes of conduct for themselves, their family and foster children to include at a minimum:

1) Guidelines on interactions between individuals
2) Monitoring behavior
3) Ensuring safe environments
4) Responding to inappropriate behavior, breaches in policy, and allegations and suspicions of child sexual abuse

(5) The Department should insert a new (B) to require pre-service education and then biennial training on mandatory reporting of child abuse that includes at a minimum:

1) Legal requirements of mandated reporters
2) Indicators of child abuse and neglect
3) Responding to suspicions, discovery or disclosure of child abuse and neglect
4) Effectively reporting child abuse and neglect

In service training should also require foster parents to received training in the protective factors that includes at a minimum concrete support in times of need for parents, knowledge of parenting and child development, social connections, parental resilience, and social and emotional development of children.

Response:

Thank you for submitting comments regarding the Children's Division (CD) regulation 13 CSR 35-60.30. The Foster Home Licensing regulations outline basic requirements for training, such as pre-service and in-service training. CD does not typically include specific training requirements in regulation as these may change more frequently. Specific training requirements are outlined in the foster parent training curriculums. Your suggested revisions will be shared with appropriate CD Central Office staff for consideration.

Comment 39
13 CSR 35-60.030 Minimum Qualifications of Foster Parents

(3) Code of conduct listed for foster parents:

1. Guidelines for foster parents when interacting with foster children.
2. How behaviors are monitored
3. How to respond to inappropriate behaviors and allegations of abuse

(5) Require training on being a Mandated Reporter, the indicators of child abuse/neglect, how to respond and report to when a disclosure of abuse is made.

Response:

Thank you for submitting comments regarding the Children's Division (CD) regulation 13 CSR 35-60.030. The Foster Home Licensing regulations outline basic requirements for training, such as pre-service and in-service training. CD does not typically include specific training requirements in regulation as these may change more frequently. Specific training requirements are outlined in the foster parent training curriculums and do include mandated reporter training and other information about responding to concerns of child abuse/neglect. Your suggested revisions for a specific "code of conduct" were shared with appropriate CD Central Office staff for consideration and will be addressed through training.

Comment 40
13 CSR 35-60.070 Foster Care Services for Youth with Elevated Needs

Behavioral Interventionist Programs need to be made readily available for elevated needs children. This program has tremendous potential but seems to have a very limited availability and the process to get approved for a B.I. is not conducive for a parent in crisis. When a parent of a behavioral needs child is in crisis and reaches out to the FST for help, they need help now-not in 30 or 60 days. There needs to be a way for a FST to get short term emergency approval of a B.I. to be placed in a home within a few days of the foster parent's request. If the emergency approval was even for only 20 hours per week for 30 days, this could mean the difference between a family that disrupts verses a family that stays together. This temporary set up could then give the FST time to go through the proper channels to get the normal approval/denial of a B.I. placement. The B.I. program is a tremendous asset but has such limited availability and people in rural counties feel like they have no resources when dealing with an elevated needs child. I firmly believe this could reduce the amount of disruptions. Families do not want to quit difficult children. The just want help while trying to do an incredibly difficult job.

Response:

Thank you for submitting comments on our regulations. 13 CSR 35-60.070 outlines the eligibility criteria for youth and resource providers. The regulation does not outline specific treatment interventions as these would be individualized for each youth.

Your suggestions regarding the Behavioral Interventionist Program will be shared with appropriate staff at the Children's Division Central Office.

Comment 41
13 CSR 35-71.010 Licensing Rules for Residential Treatment Agencies for Children and Youth

Division 35, Chapter 71 general comments: Great Circle appreciates that the state is placing an emphasis on reviewing the operating rules of the Department of Social Services. Reviewing Division 35, Chapter 71, the context used for review was how they impacted the services included in 2017: 1. The current rules were designed for agencies that provided one discrete service – 24/7 residential. 2. Many of the current agencies licensed under this rule now provide multiple services, guided by contract requirements. 3. Requires each residential treatment site to be individual licensed even if operated by one agency.
Recommendations for Action:

1. Establish an informed agency group, licensed under this statute to propose up to date best practice, focused on outcomes for children rather than rules focused on processes for DSS to consider.
2. Recognize that Chapter 73 are only rules for one program in an agency and does not cover other programs;
3. Issue one license per residential treatment agency.

Response:

Thank you for your comments regarding the Children's Division regulation 13 CSR 35-71. Your suggestions will be shared Children's Division Central Office staff for consideration.

Comment 42
13 CSR 35-71.010 Licensing Rules for Residential Treatment Agencies for Children and Youth

Carmen works for Great Circle. With modernization – what constitutes a record? Agencies now have electronic records. The regulations cover residential treatment services – not all other services an agency provides. CD should, therefore, only monitor residential treatment services. The regulations require one agency license for residential treatment services and one license for child placing agencies – why do we need a license for each facility? Residential Program Unit (RPU) staff are not fond of licensing through accreditation. There is no evidence that FCSR checks on are still needed for accredited facilities. RPU pulls records from all areas of Great Circle, not just the residential treatment piece. Can agencies send personnel records to RPU via email? They don't need the full paper file. Due to HIPAA, RPU doesn't need all of the information and employee addresses. If needed – can it be sent electronically? RPU staff have said no, because "that is the way we have always done it".

Response:

Thank you for your comments regarding the Children's Division regulation 13 CSR 35-71.010. Your suggestions regarding electronic records and monitoring of residential treatment services will be shared Children's Division Central Office staff for consideration. Your other comments and concerns will also be shared for appropriate handling.

Comment 43
13 CSR 35-100.020 Pregnancy Resource Center Tax Credit Program

St. Joseph Pregnancy Resource Center. Tax Credits have helped greatly; benefit for people making contributions and for the non-profit agency. Makes for a healthy community.

I appreciate your dedication to improve the financial burden on individuals and businesses in Missouri. The Pregnancy Resource Tax Credit is beneficial for St. Joseph Pregnancy Resource Clinic as it is an incentive for donors to contribute to our 501(c)3 organization. We are dependent on individuals and businesses for funding services to women in crisis pregnancies.

St. Joseph PRC (Pregnancy Resource Clinic) participates in the Missouri State Tax Credit program. We provide professional and caring services to pregnant, at-risk, and post-abortive women; addressing their spiritual, physical, and emotional needs; equipping them to make healthy, life-affirming decisions. We provide lab quality pregnancy tests, free limited ultrasounds, limited STD testing, pregnancy options education, parenting classes (where women can earn diapers, wipes, clothing, and baby gear), and post-abortion healing classes. We are entirely donor supported- we do not receive any state or federal funding. Each year, our donors take full advantage of the tax credit program- we regularly use up our allotment. Donors are encouraged to give because the tax credits they receive, and it directly impacts our total donations for the year. The program is efficient and well-run, with required documentation that is of the appropriate amount, and communication between the Department of Social Services and our center being excellent. If this program were to be reduced or discontinued, the impact on our center would be great, as I believe our donations would decrease. Furthermore, without any state or federal funding, the tax credit program is one way that the State has sent the message that it believes in helping women in crisis pregnancies and babies, and that is of great encouragement to our donors. We want to ask and encourage that the State continue this program.

I would be happy to discuss with you my perspective on the Pregnancy Resource Center Tax Credit Program.

Response:

Thank you for taking the time to provide positive comments regarding regulation: 13 CSR 35-100.020. The Department of Social Services (DSS) appreciates that Pregnancy Resource Center (PRC) tax credits provide additional funding for PRCs to provide services to pregnant, at-risk women. DSS also appreciates knowing the PRC tax credit program is well-run with excellent communication and will continue to provide the same customer service it does today for the tax credit program.

Comment 44
13 CSR 40-2.010 General Application Procedures

Was not sure where to put this comment. The length of time on any state assistance should be limited to a certain amount of weeks per year, or years per

life. I personally know of people that have lived on state assistance for more than 10 years. They have internet- which even I could not afford with 2 incomes into our house for many years. They always get alcohol and cigarettes no matter what. They have an income from hauling scrap or various small jobs, but do not report that to the state and it is not traceable. I have heard of drug use within the home. When they get income taxes back instead of trying to better themselves they blow through the money some way or another and have nothing to show for it. There are many people in many states that cheat the system just like this every year. It is time to have more strict rules THAT ARE ENFORCED. Unemployment makes it to where you can only receive benefits for so many weeks out of the year and you have to show you have tried to look for work in order to claim the benefits. This should also be incorporated into the state assistance policy. Yes, there are kids or infants involved in these families, but they are involved in the unemployed families too and those people actually had a job to begin with. I understand that you go through tough times. Been there, done that. Not for long though. I got out and found a job. You don't have to have a college degree for many jobs out there. Anyone who actually applies themselves and tries will find something they can do. If the people on the assistance do not like it and try to apply for jobs they know they are not qualified for then we should open up offices just like unemployment has or use the same offices with more employees in them. This would also create more jobs. Our state would have less money to pay out for assistance and more money for bridges, roads, maintenance, ETC...

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.010. 13 CSR 40-2.010 specifically describes an individual's right to apply for any program administered by the Family Support Division, but it does not include the eligibility requirements for Income Maintenance programs. The administration of each program is governed by Federal and State laws. The Family Support Division regulations located in 13 CSR 40 Chapter 2 for administering Income Maintenance programs, cannot be altered to become stricter than the Federal and State laws they are derived from. Reporting requirements for each program do exist. Processes and procedures are also in place when it is determined that a recipient of an Income Maintenance program has received benefits for which they were not entitled to receive. The Department of Social Services, Family Support Division's regulations are required to follow State and Federal law, which currently address your concerns. The objective of the Department of Social Services is to build the earning and self-sufficiency capacity of Missourians and Missouri families to secure and sustain healthy, safe, and productive lives.

Comment 45

13 CSR 40-2.030 Definitions Relating to Real and Personal Property

13 CSR 40-2.030(11)(C)—Automobile Exemption.

A TANF recipient may not own personal property with equity greater than $1000; however, 13 CSR 40-2.030(11)(C) states that the first fifteen hundred

dollars ($1500) of equity in an automobile will not be included in this determination. The $1500 equity exemption is an outdated remainder from AFDC regulations and does not promote a welfare model that is centered on employment and self-sufficiency. Following welfare reform in the 1990s,[1] most states significantly relaxed the limits on vehicle equity.[2] By 1999, nearly half of all states offered a full exemption for at least one vehicle.[3] Indeed, studies have indicated that moving from a $1500 vehicle exemption model to a full vehicle exemption model increases the probability of low-income mothers owning a car by 20%.[4] Missouri should amend its regulation to include a full vehicle exemption to better promote the goals of the TANF program—work force participation and self-sufficiency.

Automobiles are incredibly important assets for low-income individuals who are seeking employment and are the asset that most families participating in TANF are most likely to have. More than 40% of all single mothers without a high school degree have some vehicle equity, whereas only 22% of the same population has money in a checking or savings account.[5] Numerous studies have also highlighted the important relationship between vehicle ownership and employment. Low-income workers who have access to an automobile are more likely to be employed, work more hours, and, in some studies, have been found to earn more than low-income workers who do not have access to a vehicle.[6] One study of TANF recipients found that families who have access to a vehicle spend less time on public assistance and are more likely to be employed, earn higher wages, and work more hours.[7]

Because TANF participation requires that low-income families engage in work activity, Missouri should amend its regulation to best assist low-income families' ability to participate in the work force. Studies suggest that access to adequate transportation is essential for TANF recipients' stable employment. Indeed, car ownership increases the probability of being employed.[8] If Missouri wishes to promote employment, allowing a full automobile exemption is a promising first step for placing TANF recipients on the path to self-sufficiency. Excluding an automobile would also be more consistent with the Missouri Food Stamp Program

[1] See Personal Responsibility and Work Opportunity Reconciliation Act, Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 42 U.S.C).
[2] James X. Sullivan, Welfare Reform, Saving, and Vehicle Ownership: Do Asset Limits and Vehicle Exemptions Matter? 5 (Upjohn Inst. Working Paper No. 05-117., 1981), available at https://doi.org/10.17848/wp05-117.
[3] Id.
[4] Id. at 27.
[5] Id. at 5.
[6] Reid Cramer et al., A Penny Saved is Mobility Earned: Advancing Economic Mobility Through Savings, Econ. Mobility Project 27 (Nov. 2009), http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2009/empsavingsreportpdf.pdf.
[7] Tami Richards & Donald Bruce, Car Access and Employment Outcomes for Tennessee Welfare Recipients, University of Tennessee Center for Business and Economic Research 17 (2004), http://cber.bus.utk.edu/TDHS/ffjun0400.pdf.
[8] Sullivan, supra note 15, at 26.

(SNAP), which excludes all vehicles from the asset limit in recognition of the role of transportation barriers in deterring self-sufficiency and family stability.

Recommendation: Legal Services of Eastern Missouri urges FSD and the Department of Social Services to amend the vehicle exemption at 13 CSR 40-2.030(11)(C) from the first $1500 of equity in an automobile to a full automobile exemption to best promote work and self-sufficiency for TANF recipients: (11) A TANF applicant or recipient may not own personal property with equity greater than one thousand dollars ($1000). However the following personal property will not be included in this determination:

(C) One automobile;

The Temporary Assistance for Needy Families (TANF) program was created in 1996 following the adoption of the Personal Responsibility and Work Opportunity Reconciliation Act. The TANF program replaced Aid to Families with Dependent Children (AFDC) at that time. For this reason, we urge FSD and the Department of Social Services to also amend this regulation to remove reference to AFDC and replace it with TANF. The use of AFDC is outdated and inaccurate when referring to TANF eligibility.

13 CSR 40-2.030(11) states that an AFDC [TANF] recipient may not own personal property with equity greater than one thousand dollars; 13 CSR 40-2.370(3) states that "[a] participant is not eligible for Temporary Assistance if his/her total countable resources exceeds one thousand dollars ($1000). If the participant is participating in an Individual Employment Plan…the resource limit is five thousand dollars ($5000)."

By proposing an asset limit on TANF applicants and participants, Missouri limits the ability of low-income people to achieve self-sufficiency. Such limits penalize savings and ownership for low-income families and are counterproductive to the TANF program's goal of helping families achieve economic security through employment.[1] Missouri should implement regulations that encourage TANF recipients to save and increase their economic security by eliminating asset limits.

Between 2000 and 2014, seven states removed asset limits as a requirement for TANF eligibility. During that time, there were no statistically significant increases in the number of TANF recipients in those states.[2] In fact, Louisiana saw the number of recipients per capita drop by 57% after removing its asset test. Ohio experienced similar results; its TANF caseload dropped by 50%.[3]

Applying and enforcing asset limits is also burdensome and costly for state agencies that administer public assistance programs. Colorado's agency found that

[1] Rebecca Vallas & Joe Valenti, Asset Limits Are a Barrier to Economic Security and Mobility: Counterproductive Policy Deters Hardworking Americans from Savings and Ownership, CTR. FOR AM. PROGRESS (September 10, 2014), https://www.americanprogress.org/issues/poverty/reports/2014/09/10/96754/asset-limits-are-a-barrier-to-economic-security-and-mobility/.

[2] Sarah Sattelmeyer & Walter Lake, Low TANF Asset Limits Show No Cost or Caseload Benefits for State Programs, THE PEW CHARITABLE TRUSTS (Aug. 22, 2016), http://www.pewtrusts.org/en/research-and-analysis/analysis/2016/08/22/low-tanf-asset-limits-show-no-cost-or-caseload-benefits-for-state-programs.

[3] Id.

reviewing an applicant's assets took up to 90 minutes of eligibility specialist's time. That is a waste not only the agency's time, but also wastes tax payer money as only a small portion of families who seek TANF benefits have assets in excess of state limits.[1] Indeed, research found that prior to Virginia's elimination of TANF asset limits, only .5% of applications for TANF were denied due to asset limits.[2] Similarly, in Alabama in 2008, only 15 of 21,429 TANF denials were due to an applicant's excess assets.[3]

Illinois eliminated TANF asset limits in 2013. Data from the Illinois Department of Human Services confirms that very few TANF applicants in their state are found ineligible due to asset tests, but evaluating each applicant's resources is a costly and time-consuming endeavor.[4] The study found that of 192,000 individual TANF eligibility reviews conducted by the department, only eight cases were found where the applicant's assets exceeded the state's asset limit.[5] However, the administration of an asset test by an eligibility specialist cost the Illinois taxpayers nearly a million dollars annually.[6]

Research shows that most applicants to TANF have very few assets and, as a consequence, eliminating the asset tests greatly simplified program administration without significantly increasing the caseload. Because the vast majority of applicants were already living in asset poverty, removing the asset test did not greatly raise the number of new recipients. Therefore, asset test can add substantial time, effort, and cost to TANF programs, but not limit the number of people served by the program.[7]

Asset limits send a confusing message to TANF applications and participants. On one hand, the TANF program seeks to promote the value of savings and self-reliance. On the other hand, limits on saved assets discourage low-income individuals who receive TANF from having modest savings or assets.[8] The consequence of these conflicting messages is that many low-income individuals may seek to spenddown savings before applying for TANF or not apply at all—failing to access a much needed benefit.

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[1] Rebecca Vallas & Joe Valenti, Asset Limits Are a Barrier to Economic Security and Mobility: Counterproductive Policy Deters Hardworking Americans from Savings and Ownership, CTR. FOR AM. PROGRESS (September 10, 2014), https://www.americanprogress.org/issues/poverty/reports/2014/09/10/96754/asset-limits-are-a-barrier-to-economic-security-and-mobility/.

[2] Id.

[3] Id.

[4] Aleta Sprague, Illinois Senate Votes to Eliminate TANF Asset Limit, NEW AM. (May 22, 2013), https://www.newamerica.org/asset-building/the-ladder/illinois-senate-votes-to-eliminate-tanf-asset-limit/.

[5] Id.

[6] Id.

[7] Aleta Sprague & Rachel Black, State Asset Limit Reforms and Implications for Federal Policy, NEW AM. FOUND. 2-3 (Oct. 2012), https://na-production.s3.amazonaws.com/documents/state-asset-limit-reforms-and-implications-for-federal-policy.

[8] Rebecca Vallas & Joe Valenti, Asset Limits Are a Barrier to Economic Security and Mobility: Counterproductive Policy Deters Hardworking Americans from Savings and Ownership, CTR. FOR AM. PROGRESS (Sept. 10, 2014), https://www.americanprogress.org/issues/poverty/reports/2014/09/10/96754/asset-limits-are-a-barrier-to-economic-security-and-mobility/.

Savings and assets can dramatically reduce hardship for low-income families. They can also create a financial buffer for unexpected expenses and a foundation for economic mobility. The Pew Economic Mobility Project found that children whose parents are low-income but high saving are more likely to experience upward mobility than children with low-income, low-saving parents.[1] Even a small amount of savings can protect a family from disruptive events such as eviction, missed meals, utility shut offs, etc. Allowing TANF families to save may also reduce the number of months they receive benefits. Low asset limits force families to choose between accessing TANF to make ends meet or maintaining an emergency fund to prepare for their futures. Because the goal of the TANF program is to encourage self-sufficiency, Missouri should encourage low-income families to build their assets by eliminating asset tests.

Missouri should use this opportunity to amend regulations and remove its asset limits. Removing limits would enable the state to increase efficiency, reduce administrative costs, and ensure that low-income families can better access TANF.[2] Removing asset limits would also bring Temporary Assistance in line with MO HealthNet for Families, which serves a very similar population.

Recommendation:

Legal Services of Eastern Missouri urges FSD and the Department of Social Services to amend the regulations 13 CSR 40-2.030(11) & 13 CSR 40-2.310(3) to best promote saving and self-sufficiency by removing both provisions limiting TA applicant and participant asset limits.

As stated in our comments to 13 CSR 40-2.030(11)(C), we also recommend that FSD and the Department of Social Services amend the reference to AFDC in 13 CSR 40-2.030(11) to TANF. The use of AFDC is outdated and inaccurate when referring to TANF eligibility.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.030. State statute 208.010 RSMo, requires the Division "to take into account all facts and circumstances surrounding the claimant, including…income and resources…" Said section further requires the Division to investigate the transfers of assets within a certain time frame to investigate unlawful transfers. Said section also sets the asset limit at $1,000.00. A request for a rule change regarding resource limits will first need legislative approval. The objective of the Division is to ensure only eligible recipients are properly and timely enrolled.

Comment 46

13 CSR 40-2.030 Definitions Relating to Real and Personal Property

13 CSR 40-2.030(11); 13 CSR 40-2.370(3) —Removal of TANF Asset Limits

[1] Sarah Fass Hiatt & Abigail Newcomer, President Obama's Asset Limit Proposal: Supporting Families and Promoting Improved Coordination, CTR. FOR L. AND SOC. POL. 5 (July 2010), http://www.clasp.org/resources-and-publications/files/Obama-Asset-Proposal.pdf.

[2] Id.

13 CSR 40-2.030(11) states that an AFDC [TANF] recipient may not own personal property with equity greater than one thousand dollars; 13 CSR 40-2.370(3) states that "[a] participant is not eligible for Temporary Assistance if his/her total countable resources exceeds one thousand dollars ($1000). If the participant is participating in an Individual Employment Plan…the resource limit is five thousand dollars ($5000)."

By proposing an asset limit on TANF applicants and participants, Missouri limits the ability of low-income people to achieve self-sufficiency. Such limits penalize savings and ownership for low-income families and are counterproductive to the TANF program's goal of helping families achieve economic security through employment.[1] Missouri should implement regulations that encourage TANF recipients to save and increase their economic security by eliminating asset limits.

Between 2000 and 2014, seven states removed asset limits as a requirement for TANF eligibility. During that time, there were no statistically significant increases in the number of TANF recipients in those states.[2] In fact, Louisiana saw the number of recipients per capita drop by 57% after removing its asset test. Ohio experienced similar results; its TANF caseload dropped by 50%.[3]

Applying and enforcing asset limits is also burdensome and costly for state agencies that administer public assistance programs. Colorado's agency found that reviewing an applicant's assets took up to 90 minutes of eligibility specialist's time. That is a waste not only the agency's time, but also wastes tax payer money as only a small portion of families who seek TANF benefits have assets in excess of state limits.[4] Indeed, research found that prior to Virginia's elimination of TANF asset limits, only .5% of applications for TANF were denied due to asset limits.[5] Similarly, in Alabama in 2008, only 15 of 21,429 TANF denials were due to an applicant's excess assets.[6]

Illinois eliminated TANF asset limits in 2013. Data from the Illinois Department of Human Services confirms that very few TANF applicants in their state are found ineligible due to asset tests, but evaluating each applicant's

[1] Rebecca Vallas & Joe Valenti, Asset Limits Are a Barrier to Economic Security and Mobility: Counterproductive Policy Deters Hardworking Americans from Savings and Ownership, CTR. FOR AM. PROGRESS (September 10, 2014), https://www.americanprogress.org/issues/poverty/reports/2014/09/10/96754/asset-limits-are-a-barrier-to-economic-security-and-mobility/.

[2] Sarah Sattelmeyer & Walter Lake, Low TANF Asset Limits Show No Cost or Caseload Benefits for State Programs, THE PEW CHARITABLE TRUSTS (Aug. 22, 2016), http://www.pewtrusts.org/en/research-and-analysis/analysis/2016/08/22/low-tanf-asset-limits-show-no-cost-or-caseload-benefits-for-state-programs.

[3] Id.

[4] Rebecca Vallas & Joe Valenti, Asset Limits Are a Barrier to Economic Security and Mobility: Counterproductive Policy Deters Hardworking Americans from Savings and Ownership, CTR. FOR AM. PROGRESS (September 10, 2014), https://www.americanprogress.org/issues/poverty/reports/2014/09/10/96754/asset-limits-are-a-barrier-to-economic-security-and-mobility/.

[5] Id.

[6] Id.

resources is a costly and time-consuming endeavor.[1] The study found that of 192,000 individual TANF eligibility reviews conducted by the department, only eight cases were found where the applicant's assets exceeded the state's asset limit.[2] However, the administration of an asset test by an eligibility specialist cost the Illinois taxpayers nearly a million dollars annually.[3]

Research shows that most applicants to TANF have very few assets and, as a consequence, eliminating the asset tests greatly simplified program administration without significantly increasing the caseload. Because the vast majority of applicants were already living in asset poverty, removing the asset test did not greatly raise the number of new recipients. Therefore, asset test can add substantial time, effort, and cost to TANF programs, but not limit the number of people served by the program.[4]

Asset limits send a confusing message to TANF applications and participants. On one hand, the TANF program seeks to promote the value of savings and self-reliance. On the other hand, limits on saved assets discourage low-income individuals who receive TANF from having modest savings or assets.[5] The consequence of these conflicting messages is that many low-income individuals may seek to spenddown savings before applying for TANF or not apply at all—failing to access a much needed benefit.

Savings and assets can dramatically reduce hardship for low-income families. They can also create a financial buffer for unexpected expenses and a foundation for economic mobility. The Pew Economic Mobility Project found that children whose parents are low-income but high saving are more likely to experience upward mobility than children with low-income, low-saving parents.[6] Even a small amount of savings can protect a family from disruptive events such as eviction, missed meals, utility shut offs, etc. Allowing TANF families to save may also reduce the number of months they receive benefits. Low asset limits force families to choose between accessing TANF to make ends meet or maintaining an emergency fund to prepare for their futures. Because the goal of the TANF program is to encourage self-sufficiency, Missouri should encourage low-income families to build their assets by eliminating asset tests.

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[1] Aleta Sprague, Illinois Senate Votes to Eliminate TANF Asset Limit, NEW AM. (May 22, 2013), https://www.newamerica.org/asset-building/the-ladder/illinois-senate-votes-to-eliminate-tanf-asset-limit/.

[2] Id.

[3] Id.

[4] Aleta Sprague & Rachel Black, State Asset Limit Reforms and Implications for Federal Policy, NEW AM. FOUND. 2-3 (Oct. 2012), https://na-production.s3.amazonaws.com/documents/state-asset-limit-reforms-and-implications-for-federal-policy.

[5] Rebecca Vallas & Joe Valenti, Asset Limits Are a Barrier to Economic Security and Mobility: Counterproductive Policy Deters Hardworking Americans from Savings and Ownership, CTR. FOR AM. PROGRESS (Sept. 10, 2014), https://www.americanprogress.org/issues/poverty/reports/2014/09/10/96754/asset-limits-are-a-barrier-to-economic-security-and-mobility/.

[6] Sarah Fass Hiatt & Abigail Newcomer, President Obama's Asset Limit Proposal: Supporting Families and Promoting Improved Coordination, CTR. FOR L. AND SOC. POL. 5 (July 2010), http://www.clasp.org/resources-and-publications/files/Obama-Asset-Proposal.pdf.

Missouri should use this opportunity to amend regulations and remove its asset limits. Removing limits would enable the state to increase efficiency, reduce administrative costs, and ensure that low-income families can better access TANF.[1] Removing asset limits would also bring Temporary Assistance in line with MO HealthNet for Families, which serves a very similar population.

Recommendation:

Legal Services of Eastern Missouri urges FSD and the Department of Social Services to amend the regulations 13 CSR 40-2.030(11) & 13 CSR 40-2.310(3) to best promote saving and self-sufficiency by removing both provisions limiting TA applicant and participant asset limits.

As stated in our comments to 13 CSR 40-2.030(11)(C), we also recommend that FSD and the Department of Social Services amend the reference to AFDC in 13 CSR 40-2.030(11) to TANF. The use of AFDC is outdated and inaccurate when referring to TANF eligibility.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.030. The continued use of AFDC in older state regulations is at the recommendation of the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance. These regulations provide guidance when addressing open files for former AFDC participants.

Note that it appears the comment reference to 13 CSR 40-2.370 should be 13 CSR 40-2.310, Requirements as to Eligibility for Temporary Assistance..

As to the comment suggesting an elimination of asset limits for TANF, state statute 208.010 RSMo, requires the Division "to take into account all facts and circumstances surrounding the claimant, including…income and resources…" Said section further requires the Division to investigate the transfers of assets within a certain time frame to investigate unlawful transfers. Said section also sets the asset limit at $1,000.00. A request for a rule change regarding resource limits will first need legislative approval. The objective of the Division is to ensure only eligible recipients are properly and timely enrolled.

Comment 47

13 CSR 40-2.120 Methods Used to Determine the Amount of Cash Payments

Update the Standard of Need to reflect actual monthly expenses of families

13 SR 40-2.120 Methods Used to Determine the Amount of Cash Payments

The current Standard of Need (SON) for a typical family of three is $846 and has not been changed since 1993. If adjusted for inflation, the buying power of the 1993 SON would be $1,452 today.[2]

Recommendation: Replace the Standard of Need with the Federal Poverty Level (FPL), a standard used in calculating many safety net programs. The FPL is

[1] Id.

[2] Department of Labor CPI Inflation Calculator, https://data.bls.gov/cgi-bin/cpicalc.pl, accessed 09/06/2017.

not an accurate measure of the cost of living as it is based only on the costs of a "thrifty food plan" and an outdated formula related to the proportion of income families in poverty tended to spend on food versus other expenses in 1955.[1] Still the FPL is a familiar standard, utilized by a wide variety of public assistance programs, and some programs set eligibility above 100% of the FPL when it is clear that families at those income levels still need aid to access basic human needs. (For example, Missouri provides health insurance through CHIP to children in families up to 300% FPL.)

Set benefit levels to a percentage of the Federal Poverty Level, updating payments when the FPL is adjusted so that purchasing power stays constant.

13 CSR 40-2.120 Methods Used to Determine the Amount of Cash Payments This section states that the budgetary method used to determine payments "requires the determination of the needs of the individual or groups of individuals who may be affected by the receipt of assistance, the determination of income and resources available to these persons, and, if income and resources are not sufficient to provide a reasonable subsistence compatible with decency and health, the planning of assistance to meet the deficit."

The current maximum TANF benefit is only 34.5 percent of Missouri's current SON, or 27 percent of the FPL. This clearly does not meet the intent stated in the regulation.

Recommendation: Tie the TANF benefit level to a percent of the FPL. We believe it is in the interest of healthy child development for TANF payments and earnings to be able to reach 100% of the FPL without being penalized. Because accessing basic human needs with TANF benefits of only 27% of the FPL – as is current practice - is such a challenge, we recommend 75% FPL as a better standard for TANF payments. We caution against any TANF benefit lower than 50% FPL because the stress on local charitable organizations and additional family or community members, anxious to provide as much support as they can, may be too great, forcing the family into the kinds of chaos and instability described earlier.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.120. The comment included two recommendations: 1) replace 'Standard of Need' deduction with the 'Federal Poverty Level' as a means of generalizing expenses across a class of participants; and 2) making TANF payments a percentage of FPL and thus allowing TANF payments to rise automatically with FPL changes. As the comment noted, the Standard of Need deduction has not been updated for inflation since 1993. However, the proposed rule allows for clients to deduct an amount greater than the Standard of Need deduction when actual expenses are more. FSD will continue to work to build the capacity of individuals and families to secure and sustain healthy, safe, and productive lives.

[1] How We Measure Poverty," Oregon Center for Public Policy website, https://www.ocpp.org/poverty/how/, accessed 09/06/2017.

Comment 48

13 CSR 40-2.120 Methods Used to Determine the Amount of Cash Payments

13 CSR 40-2.120—Replace the Current TANF Standard of Need with the Federal Poverty Level (FPL)

The current Standard of Need (SON) for a family of three is $846 and has not been changed since 1993. If adjusted for inflation, the buying power of the 1993 SON would be $1,452 in 2017.[11]

Recommendation: Replace the Standard of Need as described in the regulations with the Federal Poverty Level, a standard used in calculating many safety net programs. The FPL is a familiar standard, utilized by a wide variety of public assistance programs (for example, Missouri provides health insurance through CHIP to children in families up to 300% of the FPL). By replacing the current Standard of Need with the FPL, TANF benefits would increase to a more reasonable amount to support the economic needs of low-income families.

13 CSR 40-2.120—Amend the TANF benefit levels to a percentage of FPL

The current maximum TANF benefit is only 34.5 percent of Missouri's current SON, or 27% of FPL. This low benefit level does not meet the intended purpose of the regulation which is to assist TANF participants when "income and resources are not sufficient to provide a reasonable subsistence compatible with decency and health."

Recommendation: Tie the TANF benefit level to a percentage of FPL. It is in the interest of healthy child development for TANF recipients to reach 100% of FPL without being penalized. Because the current level of 27% of FPL does not provide TANF recipient families with a reasonable subsistence compatible with decency and health, we recommend that no less than 50% of FPL is a better standard for TANF benefits. We would also recommend that the FPL benefit levels increase over time to 100% of FPL to better support low-income families throughout Missouri.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.120. The Federal law requires an income limit on receipt of TANF. FSD is adhering to Federal mandate. FSD will continue to work to build the capacity of individuals and families to secure and sustain healthy, safe, and productive lives.

Comment 49

13 CSR 40-2.305 Prohibition Against the Payment Of Temporary Assistance to a Person Who Has Been Convicted of Certain Felony Drug Offenses

Remove the prohibition of TANF participation because of drug-related felony offenses

[1] Department of Labor CPI Inflation Calculator, http://data.bls.gov/cgi-bin/cpicalc.pl, accessed 09/06/2017.

13 CSR 40-2.2.305 Prohibition Against the Payment of Temporary Assistance to a Person Who Has Been Convicted of Certain Felony Drug Offenses

Several years ago the General Assembly considered the compelling stories from individuals, particularly parents, who were barred from receiving SNAP benefits because of prior drug-related offenses. They clearly made a point about how this policy created yet another barrier to success for those who were trying to get their lives back on track after drug involvement. The General Assembly acted compassionately and wisely to remove that prohibition. The same should be done with the prohibition of TANF benefits. Those who have served their time, including those living in recovery from alcohol or drug dependence, deserve a second chance, especially in times of unemployment, escape from domestic violence, or other crisis situations.

Recommendation: Remove this prohibition. Note that it will require statutory change. Statute: Sections207.020 and 208.040.5, RsMo

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.305. DSS cannot remove the prohibition of payment of TANF benefits because it is required by statute.

Comment 50

13 CSR 40-2.310 Requirements as to Eligibility for Temporary Assistance

Providing adequate support to children and their families is wise both in the short run and in the end. When families cannot secure their basic human needs, they suffer and their children experience immediate negative effects that too often have life-long consequences. Toxic stress is "a chronic or frequent state of stress that can be caused by experiencing abuse, neglect, economic hardship or other adverse childhood experiences (ACEs) without the buffer of a safe, supportive adult".[1] When ACEs are experienced and toxic stress does not receive a trauma-informed response, consequences ripple throughout our society. Homelessness, decreased public safety, malnutrition and other costly health problems, increased need for special education, failure to graduate, and lower earning potential all may be side effects. The chaos of living in poverty can impact brain development.[2]

Here are some sections of TANF policy that we recommend updating by administrative and/or legislative action:

1. Eliminate unnecessary gross income tests

13 CSR 40-2.310 Requirements as to Eligibility for Temporary Assistance Three separate tests are outlined in 13 CSR 40-2.310.1

a. Under AFDC, federal law required that families had to have gross income below 185% of the state's standard of need in order to qualify. Some states retained this under TANF, although it was no longer required by federal law.

[1] Center on the Developing Child. (2015). Toxic Stress Key Concepts. http://developing child.harvard.edu/science/key-concepts/toxic-stress/

[2] National Scientific Council on the Developing Child (2005). Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper #3. http://www.developingchild.net

Mostly, the 185% of need standard is so high that it does not screen out anyone who would actually qualify to receive a benefit ($1,565 for a family of 3 in MO.)

b. Missouri has a 100% standard of need test, which is a second hurdle that applies in some circumstances. This also likely has limited impact.

c. Missouri has a percentage of Need Test that is 34.526 percent of the Standard of Need

Recommendation: Implement a single income test that disregards some portion of earned income and compare it to a Standard of Need or new poverty standard that realistically reflects the expenses of families. This reduces paperwork and creates a more efficient system that better respects the time of eligibility workers and applicants.

Simplify eligibility for two-parent families

13 CSR 40-2-310(5)(A) Requirements as to Eligibility for Temporary Assistance include detail about deprived of parental support for various reasons, but ultimately in subsection (A)(8) the rule recognizes that financial need alone is sufficient

Under AFDC, a needy child had to be "deprived" of parental support due to death, absence, incapacity or unemployment of the parents. Thus two-parent families were eligible only if a parent was incapacitated or if the primary wage-earner met special work history and unemployment tests. Under TANF, most states, including Missouri, eliminated most or all of the special two-parent rules such as the work history test. Missouri did this in a cumbersome way, retaining the concept of "deprivation" and just broadening the unemployed parent eligibility criteria. As a practical matter, the result is that a two-parent family is eligible simply based on financial need.

Recommendation: Remove the concept of "deprivation" that was borrowed from the old AFDC law and rules. This will simplify administration and avoid wasted processes. The bottom line is that a family is eligible based on financial need regardless of whether there are one or two parents in the home, so all of the process steps on incapacity or absence are really irrelevant. This is a policy that encourages formation of family structures in which two parents are in the home.

Simplify earnings disregards and design so families do not face a "cliff" after 12 months

13 CSR 40-2-310 Requirements as to Eligibility for Temporary Assistance

a. Under AFDC, federal law required this limited and complicated $30 plus 1/3 earnings disregard, which had short time limits on the 1/3 portion. Under TANF, nearly all states expanded the earnings disregards as part of "making work pay" policies. Missouri expanded the earnings disregard by providing a 12-month 67% earnings disregard for those who were already on TANF when they got a job. But the time-limited earnings disregard creates an abrupt cliff when the 12 months is used up. Missouri's system of disregarding earnings is more complicated than it needs to be, and may be a barrier to families benefitting from TANF, even if they are eligible.

Recommendation: Simplify the disregard to be 67 percent of earnings and remove the time limit. This will better support families by assuring they do not

have an abrupt drop in income after 12 months and is a way to "make work pay", similar to the earned income tax credit.

If earnings disregards are simpler to use and to explain, recipients might more clearly understand the benefit of continuing to report earnings to stay on TANF.

Note that this would require statutory change. Statute: Section 208.040(5)(1). RSMo

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.310. The Federal law requires an income limit on receipt of TANF as well as the disregard calculations. An income limit is required by 42 USC Section 603 in order for the State to qualify to receive a TANF grant.

Comment 51

13 CSR 40-2.310 Requirements as to Eligibility for Temporary Assistance

13 CSR 40-2.310(8)(B)1.D (I)—New Spouse Disregard

The Strengthening Missouri Families Act[1] implemented a new spouse disregard to apply to newly-married recipients of Temporary Assistance (TANF) for the purpose of "encourag[ing] the formation and maintenance of two-parent families." The regulation states that the disregard "begins the first day of the first month following the marriage date, in which benefits could possibly, but not necessarily, have been affected without application of [the] disregard."[2]

It is clear on the face of the statute that the purpose of the new-spouse disregard is to provide a tangible financial benefit to TANF recipients who marry.[3] By establishing the beginning of the disregard period as the first day of the first month following the marriage date, the regulation fails to consider family circumstances and impedes a recipient's ability to transition into a two-parent family. As currently written, the disregard can be applied to newly married couples with no income. In such cases, it is possible that six months may elapse without those couples receiving the economic benefit envisioned in the statute. At the end of those six months, those TANF recipients will never again be able to access the benefit of the disregard because it is a
"once-in-a-lifetime benefit."[4]

The application of a one-time disregard towards a six-month period of no household income does not encourage the formation and maintenance of two-parent families. The regulation is a restrictive interpretation of the policy that goes beyond the scope of the statute, thereby contravening the stated intention of the Strengthening Missouri Families Act.

Recommendation:

Legal Services of Eastern Missouri urges FSD and the Department of Social Services to eliminate the unduly burdensome language at 13 CSR 40-

[1] Mo. Rev. Stat. § 208.026.1 (2016).
[2] Mo. Code Regs. Ann. Tit. 13, § 40-2.310(8)(B)1.D(I) (2017).
[3] Mo. Rev. Stat. § 208.026.7 (2016) (describing the purpose of the new spouse disregard as encouraging "the formation and maintenance of two-parent families").
[4] Id.

2.310(8)(B)1.D(I) and add language that aligns with the statutory purpose of the disregard:

(A) The disregard begins the first day of the first month following the marriage date, in which benefits would have been reduced without the application of this disregard.

13 CSR 40-2.310(10)-(13)—Implement a single income test for TANF applicants

Under AFDC, federal law required that families have a gross income below 185% of the state's standard of need in order to qualify for benefits. Some states retained this after the shift to TANF, but it is not required by federal law. Currently, the 185% of need standard is so high that it does not screen out anyone who would actually qualify to receive TANF benefits ($1,565 for a family of three in Missouri). Because AFDC requirements do not apply to TANF recipients, they should no longer be used by Missouri as a means of determining TANF eligibility. The 185% need test is a redundant and unnecessary step taken by eligibility specialists at the time of application, eligibility review, and at every budget adjustment wasting FSD time and taxpayer money.

Missouri also has a 100% standard of need test and a percentage of need test that is 34.525 percent of the standard of need for TANF applicants that raises additional hurdles for applicants but has a limited impact on eligibility.

Recommendation:

Legal Services of Eastern Missouri urges FSD and the Department of Social Services to amend the regulations 13 CSR 40-2.310(10),(11),&(13) to implement a single income test. This reduces paperwork and creates a more efficient system that better utilizes the time of eligibility specialists and TANF applicants.

13 CSR 40-2.310(5)(A)—Eliminate "deprivation" standard for TANF eligibility

Under AFDC, a needy child had to be "deprived" of parental support due to death, absence, incapacity, or unemployment of his/her parents in order to access benefits. For this reason, two-parent families were eligible only if a parent was incapacitated or the primary wage-earner met special work history and unemployment tests. With the change to TANF, most states eliminated most or all of the special two-parent rules. But Missouri retained the concept of "deprivation" while broadening the unemployed parent eligibility criteria. The result is that a two-parent family is eligible for TANF simply based on financial need without the need to determine if a child is "deprived" of parental support.

Recommendation: Legal Services of Eastern Missouri urges FSD and the Department of Social Services to amend 13 CSR 40-2.31(5)(A) to eliminate the concept of "deprivation" that was borrowed from outdated AFDC regulations. Removing the concept of "deprivation" from the regulations would eliminate unneeded administrative complexity and wasted processes. A family is eligible for TANF based on financial need, regardless of whether there are one or two parents in the home, so the steps in the process to determine incapacity or absence are irrelevant.

13 CSR 40-2.310—Simplify Earnings Disregards

Missouri's earnings disregard provides a 12-month, 67% earnings disregard for TANF recipients who obtain employment while in the program. This time-limited

earnings disregard creates an abrupt cliff for the TANF recipient when the twelve months have concluded. Missouri's system of disregarding earnings is a barrier to TANF recipient families' self-sufficiency.

Recommendation: Simplify the disregard to 67% of earnings and remove the time limit. This will better support TANF recipients as they work towards employability and self-sufficiency by assuring that they do not have an abrupt drop in income after twelve months of employment. We recommend that the disregard be gradually reduced over time, e.g., 50% in the second year, 25% in the third year.

This would not require statutory change because current state law (see 208.040(5)(1) RSMo) only limits the two-thirds disregard to twelve months.

It would also be beneficial to working families and promote self-sufficiency to allow TANF applicants who are working but still poor to receive the same earnings disregard as TANF recipients. The disregard would give low-income families the boost they need to maintain their employment. This recommendation may require a statutory revision as 208.040(5)(1) RSMo limits the expanded "two-thirds" income disregard to recipients as opposed to applicants for temporary assistance, although an expanded disregard that is less than two-thirds of applicants' income would not appear to require a statutory change.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.310. The new spouse disregard follows one of the four purposes of TANF. The Federal law requires an income limit on receipt of TANF as well as the disregard calculations. An income limit is required by 42 USC Section 603 in order for the State to qualify to receive a TANF grant. State statute still refers to 'deprivation.' FSD will continue to work to build the capacity of individuals and families to secure and sustain healthy, safe, and productive lives.

Comment 52

13 CSR 40-2.315 Work Activity and Work Requirements for Recipients of Temporary Assistance

13 CSR 40-2.315(9)(F)—30 Hours to Cure Sanction

As stated in 13 CSR 40-2.315(9)(F), during a 10-week period, a participant shall "remain in sanction status…[and] [t]o end the sanction, the participant shall perform work activities for a minimum average of thirty (30) hours per week for one (1) month." The implementation of an across-the-board thirty-hour participation requirement for curing sanction does not recognize the special demands shouldered by caregivers of very small children. In fact, current state regulations and federal law require only twenty hours of work participation for families with children under six years of age.[1]

[1] Mo. Code Regs. Ann. tit. 13, §§ 40-2.310(8)(B)1.D(I) , 40-2.315(7) (2017); 42 U.S.C. § 607(c)(2)(B) (2012) ("For purposes of determining monthly participation rates under subsection (b)(1)(B)(i), a recipient who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age is deemed to be engaged in work for a month if the recipient is engaged in work for an average of at least 20 hours per week during the month.").

The regulation, as written, fails to accommodate families with very small children when families are already struggling with the additional burden of recovering from a sanction. By increasing the work requirement hours from twenty per week to thirty per week, the regulations create an undue burden for parents with young children to cure sanctions and receive necessary TANF benefits.

Recommendation: Legal Services of Eastern Missouri urges FSD and the Department of Social Services to eliminate the unduly burdensome language at 13 CSR 40-2.315(9)(F) and add language that does not unduly burden TANF recipients caring for very small children:

(F) To end the sanction, the participant shall perform work activities for a minimum average of thirty (30) hours per week for one (1) month. If the participant is a parent of a child under the age of six, the participant shall perform work activities for a minimum average of twenty (20) hours per week for one (1) month.

13 CSR 40-2.315(11)(D)—12-Week Infant Exemption

As stated in 13 CSR 40-2.315(11)(D), "participant[s] who is a single custodial parent caring for a child who has not attained twelve (12) weeks of age" are exempt from work activities for the purpose of TANF benefits. While federal law provides Missouri an option for establishing limits on work activity exemptions, the twelve-week restriction is unduly burdensome for single parents of young children. This is particularly true in light of federal law, which extends to states the option of granting twelve month exemptions for single-parent households.[1]

A twelve week exemption has a significant adverse impact on Missouri's most vulnerable families. Changing the regulation to exempt a single custodial parent for twelve months would promote family stability and well-being. Research shows that very short exemptions are especially threatening to families with infants, particularly when failure to comply with work requirements results in full-family sanctions. One study found that low-income mothers of infants were somewhat less likely to experience material hardship in states with longer exemptions from work requirements.[2] Another study found that shorter exemptions from work requirements increased the prevalence of maternal depression among welfare recipients with young children.[3] Maternal depression that goes untreated can cause significant damage to children, particularly young children, placing both a child's physical safety and her cognitive and behavioral development at risk. Maternal depression also hampers low-income mothers' ability to engage with their infants, further exposing their children to the negative effects of poverty.[4] A

[1] 42 U.S.C.S. § 607(b)(5) (2012).

[2] Marci Ybarra et al., TANF Generosity, State-provided Maternity leave and the Material Well-being of Low-income Families with Infants, (2014) (Paper presented at the Ass'n for Pub. Policy Analysis and Mgmt., Albuquerque, N.M., Nov. 6-8, 2014).

[3] Chris M. Herbst, Institute for the Study of Labor, Are Parental Welfare Work Requirements Good for Disadvantaged Children? Evidence from Age-of-Youngest-Child Exemptions (Sept. 2014) http://www.appam.org/assets/1/7/Are_Parental_Welfare_Requirements_Good_2014.pdf.

[4] Tracy Vericker et al., Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve, Urban Institute 5 (Aug. 2010), http://www.urban.org/research/publication/infants-depressed-mothers-living-poverty-opportunities-identify-and-serve.

different study found that TANF work requirements for parents of infants were associated with a 22 percent decline in breastfeeding rates at the six-month point among low-income mothers receiving WIC nutritional benefits.[1]

The types of jobs that TANF recipients and other low-income women typically have are rarely conducive to expressing milk at work.[2] Given the significant health benefits of breastfeeding, this finding is particularly troubling.

Because there is no statutory authority for the severe time restraints of the twelve-week period, the regulation should be amended to exempt single-parent TANF recipients from work activity for twelve months. Such a change would certainly be in keeping with the purpose of the Strengthening Missouri Families Act.[3]

Recommendation:

Legal Services of Eastern Missouri urges FSD and the Department of Social Services to amend the time limit of twelve weeks at 13 CSR 40-2.315(11)(D)and increase the time period to twelve months so as to best protect the health and well-being of low-income mothers and their infants:

(D) A participant who is a single custodial parent caring for a child who has not attained twelve (12) months of age;

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.315. Temporary Assistance for Needy Families participants with children under the age of six have a 20 hour a week work requirement. Those with children over the age of six have a 30 hour a week work requirement.

If an individual with a child over the age of 12 weeks meets an exemption, a temporary exclusion, or another good cause reason(s) they are not required to meet the work requirement, until that exemption, exclusion or good cause reason is satisfied.

13 CSR 40-2.315(9)(F)—30 Hours to Cure Sanction

Federal law allows for participation of parents with children under 12 months of age. The expectation for parents with children under 12 months of age, but over 12 weeks of age is consistent with labor protections afforded to other Missourians and is in turn consistent with FSD's goal of helping parents become self-sufficient and successful members of the workforce.

13 CSR 40-2.315(11)(D)—12-Week Infant Exemption

Federal law allows for the exemption of parents with children under 12 months of age. The exemption for parents with children under 12 weeks of age is consistent with labor protections afforded to other Missourians with newborn children, and is

[1] Steven J. Haider et al., Welfare Work Requirements and Child Well-Being: Evidence from the Effects of Breastfeeding, National Poverty Center 16 (May 2003), http://www.npc.umich.edu/publications/working_papers/paper3/03-3.pdf.

[2] Sylvia Guendelman et al., Juggling Work and Breastfeeding: Effects of Maternity Leave and Occupational Characteristics, 123 PEDIATRICS 1 (2009); Rachel Tolbert Kimbro, On-the-job moms: work and breastfeeding initiation and duration for a sample of low-income women, 10 MATERNAL AND CHILD HEALTH J. 19-26 (2006).

[3] Mo. Rev. Stat. § 208.026.7 (2016) (describing the purpose of the new spouse disregard as encouraging "the formation and maintenance of two-parent families").

in turn consistent with FSD's goal of helping parents become self-sufficient and successful members of the workforce.

Comment 53
Rule 13 CSR 40-2.370 Requirement that All Recipients for the Payment of Temporary Assistance Shall Complete an Assessment and May be Required to Complete an Individual Employment Plan

13 CSR 40-2.030(11); 13 CSR 40-2.370(3) —Removal of TANF Asset Limits

13 CSR 40-2.030(11) states that an AFDC [TANF] recipient may not own personal property with equity greater than one thousand dollars; 13 CSR 40-2.370(3) states that "[a] participant is not eligible for Temporary Assistance if his/her total countable resources exceeds one thousand dollars ($1000). If the participant is participating in an Individual Employment Plan…the resource limit is five thousand dollars ($5000)."

By proposing an asset limit on TANF applicants and participants, Missouri limits the ability of low-income people to achieve self-sufficiency. Such limits penalize savings and ownership for low-income families and are counterproductive to the TANF program's goal of helping families achieve economic security through employment.[1] Missouri should implement regulations that encourage TANF recipients to save and increase their economic security by eliminating asset limits.

Between 2000 and 2014, seven states removed asset limits as a requirement for TANF eligibility. During that time, there were no statistically significant increases in the number of TANF recipients in those states.[2] In fact, Louisiana saw the number of recipients per capita drop by 57% after removing its asset test. Ohio experienced similar results; its TANF caseload dropped by 50%.[3]

Applying and enforcing asset limits is also burdensome and costly for state agencies that administer public assistance programs. Colorado's agency found that reviewing an applicant's assets took up to 90 minutes of eligibility specialist's time. That is a waste not only the agency's time, but also wastes tax payer money as only a small portion of families who seek TANF benefits have assets in excess of state limits.[4] Indeed, research found that prior to Virginia's elimination of TANF

[1] Rebecca Vallas & Joe Valenti, Asset Limits Are a Barrier to Economic Security and Mobility: Counterproductive Policy Deters Hardworking Americans from Savings and Ownership, CTR. FOR AM. PROGRESS (September 10, 2014), https://www.americanprogress.org/issues/poverty/reports/2014/09/10/96754/asset-limits-are-a-barrier-to-economic-security-and-mobility/.

[2] Sarah Sattelmeyer & Walter Lake, Low TANF Asset Limits Show No Cost or Caseload Benefits for State Programs, THE PEW CHARITABLE TRUSTS (Aug. 22, 2016), http://www.pewtrusts.org/en/research-and-analysis/analysis/2016/08/22/low-tanf-asset-limits-show-no-cost-or-caseload-benefits-for-state-programs.

[3] Id.

[4] Rebecca Vallas & Joe Valenti, Asset Limits Are a Barrier to Economic Security and Mobility: Counterproductive Policy Deters Hardworking Americans from Savings and Ownership, CTR. FOR AM. PROGRESS (September 10, 2014), https://www.americanprogress.org/issues/poverty/reports/2014/09/10/96754/asset-limits-are-a-barrier-to-economic-security-and-mobility/.

asset limits, only .5% of applications for TANF were denied due to asset limits.[1] Similarly, in Alabama in 2008, only 15 of 21,429 TANF denials were due to an applicant's excess assets.[2]

Illinois eliminated TANF asset limits in 2013. Data from the Illinois Department of Human Services confirms that very few TANF applicants in their state are found ineligible due to asset tests, but evaluating each applicant's resources is a costly and time-consuming endeavor.[3] The study found that of 192,000 individual TANF eligibility reviews conducted by the department, only eight cases were found where the applicant's assets exceeded the state's asset limit.[4] However, the administration of an asset test by an eligibility specialist cost the Illinois taxpayers nearly a million dollars annually.[5]

Research shows that most applicants to TANF have very few assets and, as a consequence, eliminating the asset tests greatly simplified program administration without significantly increasing the caseload. Because the vast majority of applicants were already living in asset poverty, removing the asset test did not greatly raise the number of new recipients. Therefore, asset test can add substantial time, effort, and cost to TANF programs, but not limit the number of people served by the program.[6]

Asset limits send a confusing message to TANF applications and participants. On one hand, the TANF program seeks to promote the value of savings and self-reliance. On the other hand, limits on saved assets discourage low-income individuals who receive TANF from having modest savings or assets.[7] The consequence of these conflicting messages is that many low-income individuals may seek to spenddown savings before applying for TANF or not apply at all—failing to access a much needed benefit.

Savings and assets can dramatically reduce hardship for low-income families. They can also create a financial buffer for unexpected expenses and a foundation for economic mobility. The Pew Economic Mobility Project found that children whose parents are low-income but high saving are more likely to experience upward mobility than children with low-income, low-saving parents.[8] Even a small

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[1] Id.
[2] Id.
[3] Aleta Sprague, Illinois Senate Votes to Eliminate TANF Asset Limit, NEW AM. (May 22, 2013), https://www.newamerica.org/asset-building/the-ladder/illinois-senate-votes-to-eliminate-tanf-asset-limit/.
[4] Id.
[5] Id.
[6] Aleta Sprague & Rachel Black, State Asset Limit Reforms and Implications for Federal Policy, NEW AM. FOUND. 2-3 (Oct. 2012), https://na-production.s3.amazonaws.com/documents/state-asset-limit-reforms-and-implications-for-federal-policy.
[7] Rebecca Vallas & Joe Valenti, Asset Limits Are a Barrier to Economic Security and Mobility: Counterproductive Policy Deters Hardworking Americans from Savings and Ownership, CTR. FOR AM. PROGRESS (Sept. 10, 2014), https://www.americanprogress.org/issues/poverty/reports/2014/09/10/96754/asset-limits-are-a-barrier-to-economic-security-and-mobility/.
[8] Sarah Fass Hiatt & Abigail Newcomer, President Obama's Asset Limit Proposal: Supporting Families and Promoting Improved Coordination, CTR. FOR L. AND SOC. POL. 5 (July 2010), http://www.clasp.org/resources-and-publications/files/Obama-Asset-Proposal.pdf.

amount of savings can protect a family from disruptive events such as eviction, missed meals, utility shut offs, etc. Allowing TANF families to save may also reduce the number of months they receive benefits. Low asset limits force families to choose between accessing TANF to make ends meet or maintaining an emergency fund to prepare for their futures. Because the goal of the TANF program is to encourage self-sufficiency, Missouri should encourage low-income families to build their assets by eliminating asset tests.

Missouri should use this opportunity to amend regulations and remove its asset limits. Removing limits would enable the state to increase efficiency, reduce administrative costs, and ensure that low-income families can better access TANF.[1] Removing asset limits would also bring Temporary Assistance in line with MO HealthNet for Families, which serves a very similar population.

Recommendation: Legal Services of Eastern Missouri urges FSD and the Department of Social Services to amend the regulations 13 CSR 40-2.030(11) & 13 CSR 40-2.310(3) to best promote saving and self-sufficiency by removing both provisions limiting TA applicant and participant asset limits.

As stated in our comments to 13 CSR 40-2.030(11)(C), we also recommend that FSD and the Department of Social Services amend the reference to AFDC in 13 CSR 40-2.030(11) to TANF. The use of AFDC is outdated and inaccurate when referring to TANF eligibility.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.370 and 13 CSR 40-2.030 Definitions Relating to Real and Personal Property. The continued use of AFDC in older state regulations is at the recommendation of the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance. These regulations provide guidance when addressing open files for former AFDC participants.

13 CSR 40-2.370 does not include language regarding the asset limit for Temporary Assistance to Needy Families.

Comment 54

13 CSR 40-2.375 Medical Assistance for Families

13 CSR 40-2.375 & 13 CSR 40-7.030(2)—Amend the eligibility determination model for Family MO HealthNet to correspond with the Federal Poverty Level.

Currently, eligibility determinations for participants for Family MO HealthNet are based on a household's currently monthly income and household size and the TANF Standard of Need. Unlike every other Missouri Medicaid program, eligibility remains at an outdated flat dollar amount each year with no adjustment for inflation. Our recommendation would bring MO HealthNet for Families in line with other MO HealthNet programs and would make it more likely that the most vulnerable Missouri families have access to health care.

[1] Id.

Recommendation: We would recommend that the regulation be amended to tie eligibility for Family MO HealthNet to a percentage of the Federal Poverty Level, specifically no less than 50% of FPL and gradually increasing to 100% of FPL over time:

13 CSR 40-2.375

(1) The income limit for persons to be eligible for the Medical Assistance for Families program established pursuant to section 208.145, RSMO shall be no less than 50% of the Federal Poverty Level (FPL).

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.375 and 13 CSR 40-7.030 Participant Verification. 13 CSR 40-2.375 and 13 CSR 40-7.030 follow income guidelines set down for the MO Health Net for Families program in 208.991 (2)(2)(a) RSMo:

> "…the department shall apply the July 16, 1996, Aid to Families with Dependent Children (AFDC) income standard as converted to the MAGI equivalent net income standard."

In addition, The Patient Protection Affordable Care Act (better known as the ACA) allows us to add on an additional 5% of the Federal Poverty Level (FPL). This 5% addition is subject to any increases in the FPL. 42 CFR 435.603(d)(1)

Because there are Federal and State laws regulating the income guideline for MO HealthNet for Families, FSD cannot unilaterally increase the guidelines without a change to federal law and state statute.

Comment 55

13 CSR 40-2.420 Testing for Illegal Use of a Controlled Substance by Applicants and Recipients of Temporary Assistance

We have all heard this was voted in, however, there seems to be no mention of anyone getting drug tested. By not enforcing this rule there are lots of people living off of the state and lying about their income so they can buy their drugs. Yes there will be lots more children taken from their parents because of drug use. This will be better for the children in question than getting abused or neglected due to drugs.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-2.420. The drug testing process for Temporary Assistance for Needy Family (TANF) recipients is a two part process. Recipients must answer a screening question during the interview process to declare drug use. Recipients who answer yes are sent to drug test. In addition to the screening question, the Department of Social Services runs a quarterly match against the Missouri Highway Patrol MULES system. Individuals who get a 'hit' for an arrest, conviction or prosecution are also sent for drug testing. Those who test positive or refuse to test are disqualified for three years, unless the applicant or recipient, after having been referred by the department, enters and successfully completes a substance abuse treatment program and does not test positive for illegal use of a controlled substance in the six-month period beginning on the date of entry into

such rehabilitation or treatment program. The applicant or recipient shall continue to receive benefits while participating in the treatment program.

The children in the family continue to receive their portion of the TANF grant.

Comment 56

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

Legal Services of Eastern Missouri ("LSEM") is a nonprofit organization that provides free legal assistance to low-income clients in 21 Missouri counties in the areas of consumer law, housing, health, public benefits, family law, immigration, and education. Assisting our clients in obtaining access to health care services through Medicaid is one of our key priorities. Our Medicaid work includes assisting individuals in obtaining and maintaining access to Family MO HealthNet Programs, including MO HealthNet for Pregnant Women, and the Children's Health Insurance Program (CHIP).

Pursuant to Executive Order 17-03 and 536.175, RSMo, we have the following comments for the Department of Social Services Family Support Division regulation 13 CSR 40-7.015(4)(A) regarding who is able to apply for MO HealthNet programs.

In Missouri, nearly two thirds of the 990,000 people who access MO HealthNet benefits are under nineteen years old.[1] Children who are covered by Medicaid are more likely to do better in school, miss fewer school days due to illness or injury, and finish high school and attend college.[2] Youth enrolled in Medicaid are much more likely than uninsured children to get the preventive care they need before conditions worsen to emergency levels.[3] Medicaid beneficiaries, including those under nineteen, are more likely than those without insurance to access preventive health services such as prenatal care.[4] Despite the clear health benefits beneficiaries receive from their Medicaid coverage, the Family Support Division's (FSD) implementation of the MO HealthNet application rules in 13 CSR 40-7.015 is unduly burdensome and harmful for vulnerable unaccompanied youth and minors in Missouri. The implementation creates significant barriers for these children to access vital medical care through the MO HealthNet program. Unaccompanied youth and minors need a fair and clear avenue in which to apply for MO HealthNet benefits whether they are on their own, pregnant, or have children of their own.

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[1] Missouri Department of Social Services, Caseload Data as of October 2016.

[2] Medicaid in Missouri: 2017 Chartbook, Missouri Budget Project Presentation citing "The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions," National Bureau of Economic Research (NBER) Working Paper No. 20178, May 2014; "Childhood Medicaid Coverage and Later Life Health Care Utilization," NBER Working Paper No. 20929, February 2015; "The Long-Term Effects of Early Life Medicaid Coverage," Miller, Sarah and Laura R. Wherry," accessed at http://www-personal.umich.edu/-mille/MillerWherry_Prenatal2015.pdf.

[3] Keep Children's Health Coverage Strong: Protect Medicaid!, Children's Defense Fund, Jan. 4, 2017 available at http://www.childrensdefense.org/library/data/Medicaid-Primer _January-4-2017.pdf. "Almost 75 percent of children enrolled in Med

[4] Medicaid in Missouri: 2017 Chartbook, Missouri Budget Project Presentation.

THE VULNERABLE HEALTH STATUS OF UNACCOMPANIED YOUTH

Almost 40% of people who are homeless in the United States are youth under eighteen.5[1] In Missouri, there were 30,656 homeless students enrolled in school during the 2014-2015 school year.[2] While not all! unaccompanied youth are "homeless," they face similar barriers to health care and are often. considered "at risk" for homelessness. Homeless and at-risk youth often have more physical and mental health problems than youth who are living in a home environment.[3] Violence, abuse, or neglect in the home, as well as underage pregnancy and gender identification conflicts are often catalysts to youth being forced to leave a home environment.[4] These situations in and of themselves can lead to a greater need for health care for unaccompanied youth.

Youth not living in a home environment are more likely than housed youth to fall prey to substance use, including prescription opioid and heroin use.[5] Because of their age and vulnerability, homeless youth are at higher risk for physical and mental health consequences, including experiencing drug overdose, receiving and transmitting HIV or STls (Sexually Transmitted Infections), and having thoughts of suicide.[6] Compared to youth living in a home environment, rates of suicide attempts are much higher among homeless youth.[7] Additionally, unaccompanied youth suffer from major depression and post-traumatic stress disorder (PTSD) at higher rates than youth living in a home environment because of the traumas they have faced, both in the home they fled and while in transition.[8] Without access to MO HealthNet coverage, unaccompanied youth and minors are left without the ability to obtain the treatment necessary to fight against these devastating health consequences.

A staggering number of unaccompanied youth have had experience with pregnancy.[9] Around two-thirds of youth looking for shelter outside the home environment are female, many leaving home because of conflict surrounding the

[1] https://www.covenanthouse.org/homeless-teen-issues/statistics.

[2] Missouri Department of Elementary and Secondary Education, Statewide Homeless Data Results.available at https://dese.mo.gov/sites/default/files/qs-fc-hmls-Statewide-Homeless-Data-Results-2015.pdf.

[3] Understanding the Health Care Needs of Homeless Youth, Health Resources & Servs. Admin., Health Center Prog., Jan. 24, 2001

[4] *Id.*

[5] Id. See also Harmony Rhoades, Hailey Winetrobe, and Eric Rice, Prescription Drug Misuse Among Homeless Youth, Drug Alcohol Depend 138 (May 1, 2014).

[6] Harmony Rhoades, Hailey Winetrobe, and Eric Rice, Prescription Drug Misuse Among Homeless Youth, Drug Alcohol Depend 138 (May 1, 2014).

[7] Understanding the Health Care Needs of Homeless Youth, id. at 7. "One study of street youth…reported that up to 48 percent of homeless youth have attempted suicide with many making repeated attempts." Id.

[8] Id.

[9] Pregnant and Parenting Unaccompanied Youth, National Network for Youth, Issue Brief, available at https://www.nn4youth.org/wp-content/uploads/issueBrief_Pregnancy_and_parenting.pdf. Between 33 and 50 percent of homeless youth have had a pregnancy experience compared to youth living in a home environment, who have less that ten percent. Id. citing Greene, J.M., & Ringwalt, C.L. (1998). Pregnancy among three national samples of runaway and homeless youth. Journal of Adolescent Health, Volume 23, Issue 6. Retrieved June 7, 2007 from http://www.johonline.org/article/PIIS1054139X98000718/abstract.

pregnancy.[1] According to one study, most youth who were pregnant at 'the time they became homeless gave birth while living in transition.[2] Unaccompanied youth living in transition while pregnant and during the post-partum timeframe can experience devastating health outcomes for both their children and themselves if they are unable to access 'medical care. Without access to prenatal care, unaccompanied youth experience inadequate diet while pregnant, low-birthweight, and higher infant mortality.[3] Children born to unaccompanied youth who face barriers to health care are left vulnerable to illness, as well as miss out on other life and health outcomes that hinge on early childhood access to health care.[4] Because homeless and unaccompanied youth face such major health risks, it is imperative that they have the ability to access necessary health care.

FSD IMPLEMENTATION OF 13 CSR 40-7.015 IS UNDULY BURDENSOME ON UNACCOMPANIED YOUTH AND THREATENS THEIR HEALTH AND SAFETY

Under 13 CSR 40-7.015, FSD is denying MO HealthNet applications submitted by unaccompanied youth unless they are sixteen or seventeen and have an Authorized Representative to submit the application on their behalf. FSD only allows unaccompanied youth between the ages of sixteen and seventeen who meet the criteria of the Qualified Minor law[5] to appoint an Authorized Representative to apply for Medicaid on their behalf. If an unaccompanied youth is younger than sixteen, FSD provides no way for that child to apply for health coverage. This practice causes harm to Missouri's most vulnerable residents. For example, a pregnant fifteen year old in Kansas City was unable to obtain Medicaid in a timely manner because she did not have parents available to apply on her behalf. According to CMS guidance interpreting federal law and policies, a child's living situation should never create a barrier to his or her access to Medicaid or CHIP coverage.[6] As such, an unaccompanied youth should not be denied the right to apply for MO HealthNet based on his or her age and where he or she is living.

We urge FSD to allow all individuals including minors to apply for Medicaid. In fact, state law requires FSD to accept applications from any individual.[7] FSD's practice of allowing only older youth to apply, and even then only through an Authorized Representative, violates 42 C.F.R. § 435.907(a), as well as the aforementioned state law. At a minimum, all children must be allowed to apply with the help of an adult acting responsibly for the child. In addition to permitting an Authorized Representative to submit an application, the federal regulation

[1] Id. citing Kaiser Foundation. (2005). Percentage of Homeless Youth in 1//Illinois Who Have Been Pregnant Has More Than Doubled Over Last 20 Years, Study Says. Retrieved June 26, 2006 from http://www.kaisernetwonk.org/daily_reports/print_report.

[2] Id.

[3] Understanding the Health Care Needs of Homeless Youth, id. at 7.

[4] Id. at 2 and 3.

[5] Mo. Rev. Stat. 431.056.

[6] Letter from Cindy Mann, Director, Centers for Medicare and Medicaid Servs., to Anne Swerlick, Deputy Director of Advocacy, Florida Legal services (Oct. 21, 2013).

[7] Mo. Rev. Stat. 208.070.

requires a state to accept a Medicaid application for a minor submitted by an adult acting responsibly for the minor.[1] An Authorized Representative is not required.

Moreover, for sixteen and seventeen year olds, Missouri law authorizes minors to submit a Medicaid application when they are living independently without the support of parents.[2] Known as the Qualified Minor law, youth who meet the requirements set forth in the statute may contract for certain purposes on their own behalf including "obtaining medical care."[3] Thus, the plain language of the statute establishes that a qualified minor may obtain medical care on his or her own behalf. In order to obtain most medical care in Missouri, one must have health insurance or another way to pay for medical services received. The statute cannot be interpreted to require minors to wait until an emergency before they are allowed to seek medical care, because the statute contains no such limitation. There is also no public policy reason to impose more restrictive rules for unaccompanied minors applying for Medicaid as compared to adults. As outlined above, unaccompanied youth and minors face greater physical and mental health problems when compared to those living in a home environment. Without access to health care, these are more likely to suffer from HIV and ST!s, overdose, and attempt suicide.[4] Refusing to allow pregnant women and parents of any age to apply for MO HealthNet is not only bad policy, but contradicts Missouri-specific efforts to ensure the health of children, born and unborn.[5] Delaying the processing of applications from youth of any age who are pregnant and/or parents by requiring them to locate responsible, trustworthy adults to apply on their behalf is against public policy as well as illegal.

LSEM recently helped a seventeen year old pregnant teenager living in a shelter. She was living alone in the shelter and had no relatives to help her apply for Medicaid. The shelter, an agency devoted to helping pregnant women, referred her to us when they realized she had no health insurance and was unable to obtain it on her own. Since she had no health insurance, she faced barriers to receiving necessary prenatal care. Even with the help of a Legal Services advocate her coverage was delayed well beyond Missouri's fifteen day timeframe for processing a Medicaid for Pregnant Women application. Thus, instead of being able to focus on getting other aspects of her life in order, this future mom was required to spend valuable time going back and forth with FSD regarding what they required for her to submit an application. Since FSD does not have any clear guidance on how an unaccompanied youth can apply for MO HealthNet, she was unable to get the care she needed in a timely manner. Additionally, even though 13 CSR 40-7.015 allows parents of any age to apply on a child's behalf, FSD has recently refused to allow underage parents to apply on their children's behalf. Unaccompanied youth should

[1] 42 C.F.R. § 435.907(a).
[2] Mo. Rev. Stat.§ 431.056.
[3] Mo. Rev. Stat. § 431.056.1
[4] Id, at 9.
[5] See Show Me Healthy Babies MO HealthNet Program, MO HealthNet for Kids, MO HealthNet for Families, and the Children's Health Insurance Program. Certainly the purposes of these programs are frustrated when Missouri erects unnecessary barriers to coverage - especially barriers that harm pregnant women and their children.

not be left without health care simply because of their living situation and age, nor should their children, born and unborn alike.

A CLEAR PATH FOR UNACCOMPANIED YOUTH TO APPLY FOR MO HEALTHNET

LSEM asks for a clear path to apply for MO HealthNet benefits for all Missouri residents, including all unaccompanied youth under eighteen in compliance with federal and state law. We urge the State to adopt policies free from burdensome and harmful language detailing who can apply for MO HealthNet coverage, including minors. Currently, the policies surrounding minors and unaccompanied youth are unclear, ineffective, and confusing as to who can apply for MO HealthNet, leading to unlawful barriers for unaccompanied youth accessing MO HealthNet coverage and subsequent health care.

We urge FSD and the Department of Social Services to eliminate the unduly burdensome language on 13 CSR 40-7.015(4)(A) and add clear language such as:

(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 regardless of age;

Such an edit will ensure unaccompanied youth of any age will be able to apply for MO HealthNet benefits for themselves and their children without the unnecessary and unduly burdensome step of trying to find a trusted adult to submit an application on their behalf. By incorporating this edit into the regulations, the Department of Social Services will ensure all unaccompanied youth, including pregnant youth and youth who are parents, have access to health care that could save their and their children's health.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-7.015. The Department of Social Services, Family Support Division, is working to find solutions to allow vulnerable populations, such as unaccompanied or homeless minors, to apply for benefits as permitted under Federal and State laws, particularly 42 CFR § 435.907 which details the application process on the Federal level and §431.056, RSMo, which describes the circumstances under which a minor participant may contract for services in the State of Missouri. All MO HealthNet participants are subject to program rules and the consequences of receiving benefits for which they may not be entitled to receive. Therefore, it is important that any person signing an application for benefits be fully aware of his or her participant responsibilities.

For all minors, the Children's Division operates hotlines to take reports of suspected child abuse, neglect, and school violence. It completes investigations or family assessments in response to calls of concerns, and offers prevention services and treatment services to help children and families in need. The Department of Social Services seeks to balance the welfare of children with rights of parental control in order to keep families together. The overall objective of the Department of Social Services, Family Support Division regulations, is to carry out the laws of this State for administering MO HealthNet programs, and produce results that will strengthen Missouri families.

Comment 57
13 CSR 40-7.015 Application Procedure for Family MO HealthNet Programs and the Children's Health Insurance Program (CHIP)

Thank you for this opportunity to provide comments on regulations and policies of the Department of Social Services (DSS). Generate Health believes that St. Louis can be a more thriving region if we improve the health and well-being of our community's moms, babies and families. 260 babies die before their first birthday each year in St. Louis. Premature death is the leading cause of infant death in St. Louis. Even though St. Louis is home to some of the best medical care in the country, far too many of our babies are dying, born too soon or too small. All St. Louisans should have the opportunity to make the choices that allow them to have a healthy pregnancy or healthy baby. Unfortunately, under 13 CSR 40-7.015, the Family Support Division (FSD) is denying MO HealthNet applications submitted by unaccompanied youth unless they are sixteen or seventeen and have an Authorized Representative to apply on their behalf. The implementation of this rule creates a harmful barrier for unaccompanied pregnant youth and their children to access the medical care, including prenatal care that they need to have a healthy pregnancy or baby. Without access to prenatal care they will be at much greater risk of giving birth to a premature and/or low-birthweight baby. With infant mortality rates in some of our neighborhoods worse than some developing countries, Generate Health STL recommends that DSS update 13 CSR 40-7.015 to provide clear language to eliminate the harmful and confusing language in the current regulation.

Please consider the following revision:

(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 regardless of age.

There are many issues that impact the health of an unborn child beyond access to health care. This is one issue we can address to save the lives of babies in our state.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-7.015. The Department of Social Services, Family Support Division, is working to find solutions to allow vulnerable populations, such as unaccompanied or homeless minors, to apply for benefits as permitted under Federal and State laws, particularly 42 CFR § 435.907 which details the application process on the Federal level and §431.056, RSMo, which describes the circumstances under which a minor participant may contract for services in the State of Missouri. All MO HealthNet participants are subject to program rules and the consequences of receiving benefits for which they may not be entitled to receive. Therefore, it is important that any person signing an application for benefits be fully aware of his or her participant responsibilities.

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family assessments in response to calls of concerns, and offers prevention services and treatment services to help children and families in need. The Department of Social Services seeks to balance the welfare of children with rights of parental control in order to keep families together. The overall objective of the Department of Social Services, Family Support Division regulations, is to carry out the laws of this State for administering MO HealthNet programs, and produce results that will strengthen Missouri families.

Comment 58
13 CSR 40-7.015 Application Procedure for Family MO HealthNet Programs and the Children's Health Insurance Program (CHIP)

Teen Pregnancy & Prevention Partnership's Comments on Missouri Department of Social Services Regulations 13 CSR 40-7.015(4)(A) – Application Procedure for MO HealthNet

Thank you for this opportunity to address the needs of adolescents in the regulations and policies of the Department of Social Services (DSS). The Teen Pregnancy & Prevention Partnership is a Missouri nonprofit organization whose mission is to promote teen pregnancy prevention and adolescent sexual health by uniting Missouri through advocacy, collaboration, training and public awareness. We recognize the impact of social and health disparities on teen pregnancy and adolescent sexual health and support efforts to improve access to services.

Pregnant and parenting teens are vulnerable to negative health outcomes for themselves and their children if they are unable to access care and prevention services. According to Child Trends, "Young women in their teens are by far the least likely to receive timely prenatal care. In 2014, 25 percent of births to females under age 15, and 10 percent of births to teens ages 15 to 19, were to those receiving late or no prenatal care."1

Under 13CSR 40-7.015, the Family Support Division (FSD) is denying MO HealthNet applications submitted by unaccompanied/homeless youth unless they are sixteen or older and have an Authorized Representative. This can cause unnecessary delays for young people who need time-sensitive services such as early prenatal care. Without access to prenatal care, pregnant youth may experience undiagnosed complications, low-birthweight, and higher infant mortality. We respectfully propose that unaccompanied youth should be able to apply independently and not have to utilize an Authorized Representative on their application in order to remove barriers to care.

Please consider the following revision to clarify the application procedure for all eligible participants:

(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 **regardless of age;**

By revising the regulation, the Department of Social Services can increase the likelihood that pregnant teens have access to early prenatal care which can significantly improve their health and the health of their children.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-7.015. The Department of Social Services, Family Support Division is working to find solutions to allow vulnerable populations, such as unaccompanied or homeless minors, to apply for benefits as permitted under Federal and State laws, particularly 42 CFR § 435.907 which details the application process on the Federal level and §431.056, RSMo, which describes the circumstances under which a minor participant may contract for services in the State of Missouri. All MO HealthNet participants are subject to program rules and the consequences of receiving benefits for which they may not be entitled to receive. Therefore, it is important that any person signing an application for benefits be fully aware of his or her participant responsibilities.

For all minors, the Children's Division operates hotlines to take reports of suspected child abuse, neglect, and school violence. It completes investigations or family assessments in response to calls of concerns, and offers prevention services and treatment services to help children and families in need. The Department of Social Services seeks to balance the welfare of children with rights of parental control in order to keep families together. The overall objective of the Department of Social Services, Family Support Division regulations, is to carry out the laws of this State for administering MO HealthNet programs, and produce results that will strengthen Missouri families.

Comment 59

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

Comments on Missouri Department of Social Services Regulations 13 CSR 40-7.015(4)(A) – Application Procedure for MO HealthNet

For more than 20 years, Vision for Children at Risk has worked to assure the well-being of children and youth, with a particular emphasis on children who are at greatest risk. Our work includes informing the community about the needs of children through education and a primary data product, The Children of Metropolitan St. Louis: a Data Book for the Community. We build and drive collaborative action to address children's priority needs, and we advocate for policies and that support the well-being of children and their families. Vision for Children at Risk is a non-profit organization. Since we do not provide direct services, our advocacy is solely for the benefit of the common good.

Thanks for this opportunity to provide comments on Department of Social Services regulations.

Partners have brought to our attention the significant barriers that unaccompanied minors face in applying for Mo HealthNet. Our comments apply to13 CSR 40-7.015(4)(A).

There is a substantial body of research that indicates the positive benefits of health insurance for both pregnant women and children. Children who are covered by Medicaid are more likely to do better in school, miss fewer school days due to

illness or injury, and finish high school and attend college.[1] Youth enrolled in Medicaid are much more likely than uninsured children to get the preventive care they need before conditions worsen to emergency levels.[2] Research also shows that infant mortality and children who are born at low birth weights are more prevalent in low-income areas with higher numbers of children who are at risk for bad outcomes. In the United States, the infant mortality rate is 5.8 deaths per 1,000 live births. With the exception of two zip codes, the infant mortality rate in the City of St. Louis exceeds that national average. In St. Louis County, the same is true of almost every zip code north of I-64. The number of children born with low birth weight show a similar pattern.[3] Unaccompanied youth and minors are among the youth at highest risk for negative outcomes such as homelessness, drug use, sexually transmitted infections, depression, post-traumatic stress disorder and suicide. They need a fair and clear avenue in which to apply for MO HealthNet benefits whether they are on their own, pregnant, or have children of their own.

Allowing easy access to health care is an important step in mitigating the difficult life experiences of young unaccompanied youth.

Under 13 CSR 40-7.015, the Family Support Division denies MO HealthNet applications submitted by unaccompanied youth unless they are sixteen or seventeen and have an Authorized Representative to submit the application on their behalf. FSD only allows unaccompanied youth between the ages of sixteen and seventeen who meet the criteria of the Qualified Minor law[4] to appoint an Authorized Representative to apply for Medicaid on their behalf. If an unaccompanied youth is younger than sixteen, FSD provides no way for that child to apply for health coverage. This practice causes harm to Missouri's most vulnerable residents.

Delaying the processing of applications from youth of any age who are pregnant and/or parents by requiring them to locate responsible, trustworthy adults to apply on their behalf is against public policy as well as illegal. These unaccompanied minors' efforts to care for themselves and their children are being made more difficult by a rule that simply does not make sense.

Vision for Children at Risk urges the Family Support Division and the Department of Social Services to eliminate the unduly burdensome language on 13 CSR 40-7.015(4)(A) and add clear language such as:

> (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 ***regardless of age;***

[1] Medicaid in Missouri: 2017 Chartbook, Missouri Budget Project. Available at www.mobudget.org

[2] Keep Children's Health Coverage Strong: Protect Medicaid!, Children's Defense Fund, Jan. 4, 2017 available at http://www.childrensdefense.org/library/data/Medicaid-Primer_January-4-2017.pdf. "Almost 75 percent of children enrolled in Medicaid had a preventive well-child visit in the past year, compared to just 41 percent of uninsured children." Id.

[3] The Children of Metropolitan St. Louis: a Data Book for the Community. Vision for Children at Risk, October 2017.

[4] Mo. Rev. Stat. 431.056.

Doing this ensures that unaccompanied youth will ensure unaccompanied youth of any age will be able to apply for MO HealthNet benefits for themselves and their children without the unnecessary and unduly burdensome step of trying to find a trusted adult to submit an application on their behalf.

Again, thank you for this opportunity to provide comments. If you have questions or need additional information, please contact me.

Ruth Ehresman, Advocacy Coordinator, rehresman@visionforchildren.org 314.534.6015

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-7.015. The Department of Social Services, Family Support Division is working to find solutions to allow vulnerable populations, such as unaccompanied or homeless minors, to apply for benefits as permitted under Federal and State laws, particularly 42 CFR § 435.907 which details the application process on the Federal level and §431.056, RSMo, which describes the circumstances under which a minor participant may contract for services in the State of Missouri. All MO HealthNet participants are subject to program rules and the consequences of receiving benefits for which they may not be entitled to receive. Therefore, it is important that any person signing an application for benefits be fully aware of his or her participant responsibilities.

For all minors, the Children's Division operates hotlines to take reports of suspected child abuse, neglect, and school violence. It completes investigations or family assessments in response to calls of concerns, and offers prevention services and treatment services to help children and families in need. The Department of Social Services seeks to balance the welfare of children with rights of parental control in order to keep families together. The overall objective of the Department of Social Services, Family Support Division regulations, is to carry out the laws of this State for administering MO HealthNet programs, and produce results that will strengthen Missouri families.

Comment 60

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

Teen Pregnancy & Prevention Partnership's Comments on Missouri Department of Social Services Regulations 13 CSR 40-7.015(4)(A) – Application Procedure for MO HealthNet

Thank you for this opportunity to address the needs of adolescents in the regulations and policies of the Department of Social Services (DSS). The Teen Pregnancy & Prevention Partnership is a Missouri nonprofit organization whose mission is to promote teen pregnancy prevention and adolescent sexual health by uniting Missouri through advocacy, collaboration, training and public awareness. We recognize the impact of social and health disparities on teen pregnancy and adolescent sexual health and support efforts to improve access to services.

Pregnant and parenting teens are vulnerable to negative health outcomes for themselves and their children if they are unable to access care and prevention

services. According to Child Trends, "Young women in their teens are by far the least likely to receive timely prenatal care. In 2014, 25 percent of births to females under age 15, and 10 percent of births to teens ages 15 to 19, were to those receiving late or no prenatal care."

Under 13 CSR 40-7.015, the Family Support Division (FSD) is denying MO HealthNet applications submitted by unaccompanied/homeless youth unless they are sixteen or older and have an Authorized Representative. This can cause unnecessary delays for young people who need time-sensitive services such as early prenatal care. Without access to prenatal care, pregnant youth may experience undiagnosed complications, low-birthweight, and higher infant mortality. We respectfully propose that unaccompanied youth should be able to apply independently and not have to utilize an Authorized Representative on their application in order to remove barriers to care.

Please consider the following revision to clarify the application procedure for all eligible participants:

(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 **regardless of age;**

By revising the regulation, the Department of Social Services can increase the likelihood that pregnant teens have access to early prenatal care which can significantly improve their health and the health of their children.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-7.015. The Department of Social Services, Family Support Division is working to find solutions to allow vulnerable populations, such as unaccompanied or homeless minors, to apply for benefits as permitted under Federal and State laws, particularly 42 CFR § 435.907 which details the application process on the Federal level and §431.056, RSMo, which describes the circumstances under which a minor participant may contract for services in the State of Missouri. All MO HealthNet participants are subject to program rules and the consequences of receiving benefits for which they may not be entitled to receive. Therefore, it is important that any person signing an application for benefits be fully aware of his or her participant responsibilities.

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Comment 61

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

Comments on Missouri Department of Social Services Regulations 13 CSR 40-7.015(4)(A) – Application Procedure for MO HealthNet

For more than 20 years, Vision for Children at Risk has worked to assure the well-being of children and youth, with a particular emphasis on children who are at greatest risk. Our work includes informing the community about the needs of children through education and a primary data product, The Children of Metropolitan St. Louis: a Data Book for the Community. We build and drive collaborative action to address children's priority needs, and we advocate for policies and that support the well-being of children and their families. Vision for Children at Risk is a non-profit organization. Since we do not provide direct services, our advocacy is solely for the benefit of the common good.

Thanks for this opportunity to provide comments on Department of Social Services regulations.

Partners have brought to our attention the significant barriers that unaccompanied minors face in applying for Mo HealthNet. Our comments apply to13 CSR 40-7.015(4)(A).

There is a substantial body of research that indicates the positive benefits of health insurance for both pregnant women and children. Children who are covered by Medicaid are more likely to do better in school, miss fewer school days due to illness or injury, and finish high school and attend college.[1] Youth enrolled in Medicaid are much more likely than uninsured children to get the preventive care they need before conditions worsen to emergency levels.[2] Research also shows that infant mortality and children who are born at low birth weights are more prevalent in low-income areas with higher numbers of children who are at risk for bad outcomes. In the United States, the infant mortality rate is 5.8 deaths per 1,000 live births. With the exception of two zip codes, the infant mortality rate in the City of St. Louis exceeds that national average. In St. Louis County, the same is true of almost every zip code north of I-64. The number of children born with low birth weight show a similar pattern.[3] Unaccompanied youth and minors are among the youth at highest risk for negative outcomes such as homelessness, drug use, sexually transmitted infections, depression, post-traumatic stress disorder and suicide. They need a fair and clear avenue in which to apply for MO HealthNet benefits whether they are on their own, pregnant, or have children of their own.

Allowing easy access to health care is an important step in mitigating the difficult life experiences of young unaccompanied youth.

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[1] Medicaid in Missouri: 2017 Chartbook, Missouri Budget Project. Available at www.mobudget.org

[2] Keep Children's Health Coverage Strong: Protect Medicaid!, Children's Defense Fund, Jan. 4, 2017 available at http://www.childrensdefense.org/library/data/Medicaid-Primer_January-4-2017.pdf. "Almost 75 percent of children enrolled in Medicaid had a preventive well-child visit in the past year, compared to just 41 percent of uninsured children." Id.

[3] The Children of Metropolitan St. Louis: a Data Book for the Community. Vision for Children at Risk, October 2017.

Under 13 CSR 40-7.015, the Family Support Division denies MO HealthNet applications submitted by unaccompanied youth unless they are sixteen or seventeen and have an Authorized Representative to submit the application on their behalf. FSD only allows unaccompanied youth between the ages of sixteen and seventeen who meet the criteria of the Qualified Minor law[4] to appoint an Authorized Representative to apply for Medicaid on their behalf. If an unaccompanied youth is younger than sixteen, FSD provides no way for that child to apply for health coverage. This practice causes harm to Missouri's most vulnerable residents.

Delaying the processing of applications from youth of any age who are pregnant and/or parents by requiring them to locate responsible, trustworthy adults to apply on their behalf is against public policy as well as illegal. These unaccompanied minors' efforts to care for themselves and their children are being made more difficult by a rule that simply does not make sense.

Vision for Children at Risk urges the Family Support Division and the Department of Social Services to eliminate the unduly burdensome language on 13 CSR 40-7.015(4)(A) and add clear language such as:

> (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 ***regardless of age;***

Doing this ensures that unaccompanied youth will ensure unaccompanied youth of any age will be able to apply for MO HealthNet benefits for themselves and their children without the unnecessary and unduly burdensome step of trying to find a trusted adult to submit an application on their behalf.

Again, thank you for this opportunity to provide comments. If you have questions or need additional information, please contact me at (573) 636-4060, ext. 11, or via email at mtrupiano@mfhc.org.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-7.015. The Department of Social Services, Family Support Division is working to find solutions to allow vulnerable populations, such as unaccompanied or homeless minors, to apply for benefits as permitted under Federal and State laws, particularly 42 CFR § 435.907 which details the application process on the Federal level and §431.056, RSMo, which describes the circumstances under which a minor participant may contract for services in the State of Missouri. All MO HealthNet participants are subject to program rules and the consequences of receiving benefits for which they may not be entitled to receive. Therefore, it is important that any person signing an application for benefits be fully aware of his or her participant responsibilities.

For all minors, the Children's Division operates hotlines to take reports of suspected child abuse, neglect, and school violence. It completes investigations or family assessments in response to calls of concerns, and offers prevention services and treatment services to help children and families in need. The Department of

[4] Mo. Rev. Stat. 431.056.

Social Services seeks to balance the welfare of children with rights of parental control in order to keep families together. The overall objective of the Department of Social Services, Family Support Division regulations, is to carry out the laws of this State for administering MO HealthNet programs, and produce results that will strengthen Missouri families.

Comment 62
13 CSR 40-7.030 Participant Verification

13 CSR 40-2.375 & 13 CSR 40-7.030(2)—Amend the eligibility determination model for Family MO HealthNet to correspond with the Federal Poverty Level.

Currently, eligibility determinations for participants for Family MO HealthNet are based on a household's currently monthly income and household size and the TANF Standard of Need. Unlike every other Missouri Medicaid program, eligibility remains at an outdated flat dollar amount each year with no adjustment for inflation. Our recommendation would bring MO HealthNet for Families in line with other MO HealthNet programs and would make it more likely that the most vulnerable Missouri families have access to health care.

Recommendation: We would recommend that the regulation be amended to tie eligibility for Family MO HealthNet to a percentage of the Federal Poverty Level, specifically no less than 50% of FPL and gradually increasing to 100% of FPL over time:

13 CSR 40-7.030

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

(C) The income limit for persons to be eligible for the Medical Assistance for Families program established pursuant to section 208.145, RSMO shall be no less than 50% of the Federal Poverty Level (FPL).

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-7.030. 13 CSR 40-2.375 and 13 CSR 40-7.030 follow income guidelines set down for the MO Health Net for Families program in 208.991 (2)(2)(a) RSMo:

> "…the department shall apply the July 16, 1996, Aid to Families with Dependent Children (AFDC) income standard as converted to the MAGI equivalent net income standard."

In addition, The Patient Protection Affordable Care Act (better known as the ACA) allows us to add on an additional 5% of the Federal Poverty Level (FPL). This 5% addition is subject to any increases in the FPL. 42 CFR 435.603(d)(1)

Because there are Federal and State laws regulating the income guideline for MO HealthNet for Families, FSD cannot unilaterally increase the guidelines without a change to federal law and state statutes.

Comment 63
13 CSR 40-7.040 Verification Procedures

LSEM's Comments on Missouri Department of Social Services Regulations 13 CSR

40-7.040 – Verification Procedures

Legal Services of Eastern Missouri ("LSEM") is a nonprofit organization that provides free legal assistance to low-income clients in 21 Missouri counties in the areas of consumer law, housing, health, public benefits, family law, immigration, and education. Assisting our clients in obtaining access to Medicaid and other public benefits is one of our key priorities. Our Medicaid work includes assisting individuals in obtaining and maintaining access to Family MO HealthNet Programs, including MO HealthNet for Pregnant Women, and the Children's Health Insurance Program (CHIP).

Pursuant to Executive Order 17-03 and 536.175, RSMo, we have the following comments for the Department of Social Services Family Support Division regulation 13 CSR 40-7.040(2)(A-C) regarding the 10 day verification period.

FSD IMPLEMENTATION OF 13 CSR 40-7.040 IS UNDULY BURDENSOME

Under 13 CSR 40-7.040, FSD denies applications and terminates benefits for individuals who fail to submit eligibility verification documents within a ten day time period. Despite the purpose of this regulation which is "to explain what [v]erification [p]rocedures the Family Support Division will use when determining eligibility for Family MO HealthNet programs and the Children's Health Insurance Program (CHIP)," FSD applies this verification standard to all benefits programs administered by the Department of Social Services, including the Supplemental Nutrition Assistance Program (SNAP) and MO HealthNet for Aged, Blind, and Disabled (MHABD). This time frame is unduly burdensome, and leads to extremely high levels of procedural denials and terminations of all benefits administered by the Family Support Division.

System-wide challenges with the application process, the FSD call center, MEDES, and the resulting back log of cases have posed significant burdens on both applicants and recipients. Since 2014, there have been thousands affected by the flaws in the system. As a result of the transition and MEDES implementation, pregnant mothers went without lab work and other prenatal services, pediatricians refused to see newborns, and some applicants waited over 90 days to see their coverage start.[1] While the process has been shortened since its implementation, problems still remain as two botched state contracts for verification programs have fallen short of expectations.[2] The short, ten day time frame to supply the requested verification documentation could be significantly impacted by any system error or delay. These problems are exacerbated when

[1] See Tara Kulash, Long line for Medicaid Leaves Many Unsure About Eligibility, ST. LOUIS POST DISPATCH (Feb. 22, 2014), www.stltoday.com/news/special-reports/mohealth/long-line-for-medicaid-leaves-many-unsure-about-eligibility/article_c560f8f3-eda7-58fa-bbe3-043db80da46b.html.

[2] See Kurt Erickson, State Plan to Check on Welfare Scammers Floundering, ST. LOUIS POST DISPATCH (Aug. 11, 2017), www.stltoday.com/news/local/govt-and-politics/state-plan-to-check-on-welfare-scammers-floundering/article_7bef72f6-452c-5a22-b2dc-aa3d8175aed6.html

weekends and holidays are involved. In addition, FSD's adoption of a central mail hub means that requests for verification are not always mailed the day they are printed. The timeline for verification documents needs to account for these systemic challenges.

In addition, the types of verification requested by the agency are often difficult to procure in a short amount of time. The participant must frequently rely upon third parties (banks, employers, etc.) to produce the information, and he or she has no control over how quickly this third party cooperates. This is especially true for participants who are low income and have limited resources, including limited access to transportation.

Legal Services of Eastern Missouri recommends that an additional five (5) days be added to the deadline to account for delays in the mailing process of these notifications and enable applicants and participants a more reasonable time to produce the requested verification documents.

FSD APPLICATION OF 13 CSR 40-7.040 VIOLATES FEDERAL LAW

13 CSR 40-7.040(2)(A) states that "the participant shall provide the required verification within ten (10) days from the date that the division requests the information in writing." It goes on to state, "[i]f 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." 13 CSR 40-7.040(2)(C).

However, per 42 CFR 435.916 (A)(3)(B), if the agency cannot renew eligibility with existing information, then they must provide at least 30 days from the date of the renewal form to respond and provide any necessary information through any of the modes of submission.

FSD's requirement that an applicant or participant produce the requested information within the ten days is inconsistent with what is required by federal law, at least for cases of renewal or reevaluation.

While the above-cited federal regulation applies to Medicaid, the harm to low-income Missourians applies across all programs, as does the wasteful churning of the caseload from unnecessary terminations and reapplications.

VULNERABLE HEALTH STATUS OF THIS POPULATION

Missourians receiving Medicaid, SNAP, and other FSD administered benefits are already a vulnerable population at risk. The additional burdens this regulation adds adversely affects their health and safety by making it more difficult for them to receive the benefits they need to survive. For example, SNAP participation is associated with a decreased risk of hospitalization.[3]

RECOMMENDATIONS Legal Services of Eastern Missouri urges FSD and the Department of Social Services to eliminate the unduly burdensome language at 13

[3] See Laura J. Samuel et. al., Does the Supplemental Nutrition Assistance Program Affect Hospital Utilization Among Older Adults? The Case of Maryland, POPULATION HEALTH MANAGEMENT (July 6, 2017) (http://online.liebertpub.com/doi/10.1089/pop.2017.0055)

CSR 40-7.040(2)(A) and add clear language to apply to all FSD administered benefits:

(A) The participant shall provide the required verification fifteen (15) days from the date that the division requests the information in writing.

Except in instances where the individual is renewing eligibility for MO HealthNet, then the Family Support Division must provide thirty (30) days from the date of the renewal form to provide requested information to the Division.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-7.040. 13 CSR 40-7.040 explains what verification procedures the Family Support Division use when determining eligibility for Family MO HealthNet programs and the Children's Health Insurance Program (CHIP). This regulation simply promulgates the federal rules for Family MO HealthNet programs.

42 CFR 435.916 (A)(3)(B) applies only to annual renewals. It states that if the agency is not able to determine eligibility through information already available at the time of the annual renewal, the participant will be mailed a renewal form and be given 30 days to respond. The agency does give participants 30 days to respond to the annual renewal form.

42 CFR 435.916 (A)(3)(B) does not apply to verification requested when a participant reports a change in circumstance between certification periods that could affect continued eligibility. It also does not alter the timeframes established in 42 CFR 435.912(c)(3)(ii) which stipulates that that eligibility determinations for applications and changes in circumstance must be completed by the agency within 45 days from the time the participant submits the application or reports a change.

The Family Support Division is expected to complete application processing in thirty days for most Family MO HealthNet programs and within fifteen days for MO HealthNet for Pregnant Women and Show Me Healthy Babies programs. When a participant applies for coverage or reports a change in circumstance, the agency must review the reported information and determine whether or not more information is needed from the participant to make a determination. In some cases, the information received from the participant is not complete or not conclusive enough to make an eligibility determination and follow-up with the participant is needed. FSD gives the participant an additional ten days to comply. 42 CFR 435.912(c)(3)(ii) dictates that the entire exchange and final eligibility determination be made within 45 days. Therefore, the Family Support Division allows participants ten days to submit requested verifications in order to stay within this federally mandated timeframe.

Comment 64

13 CSR 40-7.040 Verification Procedures

Amend the Ten-Day Verification Deadline to allow time for mailing and to honor the reality that families in extreme poverty face many challenges when trying to obtain verification documents

13 CSR 40-7.040(2)(A-C)

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.

Parents living in dire poverty who apply for and/or receive TANF often have transportation challenges and little access to public transportation. They seldom have access to internet – unless obtained at a public institution such as a library and then may be limited to 15 minutes of use or may have had no training in using computers, leading to fruitless attempts at communicating with agencies by email. Often they run out of minutes on their phones and do without phone service for weeks at a time. In rural parts of the state, given distances between agencies such as the Family Support Division, banks, doctors' offices, court houses, and other places an applicant might have to go to obtain records, ten days will be an impossible challenge for many.

Recommendation: The Social Security Administration adds five days for mailing to their ten day deadline. A compassionate and realistic rule for TANF households would be ten business days, plus five additional days to allow for mailing, after the date of an adverse action notice.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-7.040. 13 CSR 40-7.040 explains what verification procedures the Family Support Division use when determining eligibility for Family MO HealthNet programs and the Children's Health Insurance Program (CHIP). This regulation simply promulgates rules for Family MO HealthNet programs as consistent with the federal rules.

Comment 65
13 CSR 40-7.040 Verification Procedures

As Legal Services of Eastern Missouri stated in comments submitted to the agency on September 7, 2017, FSD and the Department of Social Services should amend verification requirements for TANF applicants and participants. The current deadline of ten days is unduly burdensome for low-income TANF recipients who have transportation challenges and limited access to Internet and fax machines.

Recommendation: Legal Services of Eastern Missouri urges FSD and the Department of Social Services to eliminate the unduly burdensome language at 13

CSR 40-7.040(2)(A) and add clear language to apply to all FSD administered benefits:

(A) The participant shall provide the required verification fifteen (15) days from the date the division requests the information in writing.

Except in instances where the individual is renewing eligibility for MO HealthNet, then the Family Support Division must provide thirty (30) days from the date of the renewal form to provide requested information to the Division.

Response:

Thank you for your comments regarding the Family Support Division's regulation 13 CSR 40-7.040. 13 CSR 40-7.040 explains what verification procedures the Family Support Division use when determining eligibility for Family MO HealthNet programs and the Children's Health Insurance Program (CHIP). This regulation simply promulgates rules for Family MO HealthNet programs as consistent with the federal rules.

Comment 66

13 CSR 40-73.010 Definitions for Licensing of Child Placing Agencies

Clarify the definition of kinship home, appears to not reflect current statute

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 40-73.010.

You are correct - "Kinship" homes are not clearly defined in the regulation for Licensing of Child Placing Agencies. This regulation has not been updated since 1997 and portions of the regulation are out dated. The Children's Division is in the process of drafting an amendment to this regulation.

Your suggestion of clarifying the definition of "kinship" will be provided to the appropriate Children's Division staff.

Comment 67

13 CSR 40-73.055 Health Care

40-73.055 1 C – Clarify when the written authorization for emergency and medical care should be received when entering care. – Recommendation – include "upon entering".

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 40-73.055.

You recommended the Children's Division clarify this section by adding the phrase "upon entering". However, 40-73.055(1)(C) already includes this phrase: "the agency shall obtain written authorization for each child from the parent(s), guardian or legal custodian for emergency medical care, emergency surgical care, necessary immunizations and general medical care upon entering care."

Comment 68

13 CSR 40-73.060 Recommendation for Foster Home Licensing

40-73.060 8 A – Clarification on timeline for response to the agency, by the child placing agency, when a complaint is received that might indicate a violation of the foster home licensing rules.

Recommendation – Clarify expectation and review if the state 5 days in the rule is reasonable.

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 40-73.060. You suggest clarifying 40-73.060(8)(A) - the timeline for the child placing agency to notify the Division of a potential violation of the foster home licensing rules. The regulation states the agency shall notify the Division within five (5) days of a potential licensing violation and a recommendation regarding the license. This timeframe is a specific requirement for the child placing agency and, therefore, is not included in the Foster Home Licensing Rules.

Your suggestion of reviewing the five (5) day timeframe to determine if this is reasonable will be shared with appropriate Children's Division staff for review.

Comment 69

13 CSR 40-73.070 Placement of Children in Foster Family Homes

40-73.070 2 - This section addresses if an agency places a child in the home recommended for licensure through another agency, there is a written agreement.

Recommendation – Add at the end of this section, "for EACH CHILD."

40-73.070.3 – Again clarify that a written agreement is for "Each Child" in the placement with the foster parent. Recommendation - Add EACH CHILD in the rule for clarification.

In addition to these comments, Great Circle offers two recommendations for Division 70, Missouri Health Net, Behavioral Health rules:

Delete 70-98.015 3.A.3 – remove the section that limits MHD billable hours to 150 and recommend that billable hours are based on diagnosis, treatment and outcomes.

Question how section 70-98.020 (5) is impacted by mental health parity, again limiting sessions, rather than an individual outcome based approach to treatment.

Response:

Thank you for submitting comments regarding the Children's Division regulation 13 CSR 40-73.070. You recommend the Children's Division add the phrase "for each child" in sections 40-73.070(2) and 40-73.070(3). The current regulation already includes the phrase "for each child" in both of the referenced sections.

Your suggestion regarding the MO HealthNet Division has been referred to that agency for response.

Comment 70

13 CSR 40-79.010 Domestic Violence Shelter Tax Credit

50% tax credits are hard to sell. There are trafficking issues in South Central MO – internet dating. NAP credits helped get footing for the shelter. It would not

be able to operate without the DSS DV funding. It's 90% of the foundation funding. Agape House is struggling to get participation for tax credit. Victims did live interviews for radio as part of fundraiser. Maybe if there is a higher percentage of credit, Agape House might be able to get more participation. Maybe target the Houston area to help bring more donors.

Response:

Thank you for submitting comments on our regulation: 13 CSR 40-79.010 Domestic Violence Shelter Tax Credit. The Department of Social Services (DSS) appreciates that Domestic Violence (DV) tax credits provide additional funding for DV programs. The 50% return for the donation to DV tax credit programs is set in statute. DSS acknowledges the ideas put forth for additional ways to potentially gain more interest in DV tax credits and suggests asking other DV programs what they do to gain interest in citizens making donations.

Comment 71

13 CSR 40-79.010 Domestic Violence Shelter Tax Credit Program

St. Martha's Hall is an emergency shelter that receives Missouri Domestic Violence Shelter Tax Credits and believes that they are an incredibly good use of taxpayer dollars by amplifying the amount that a donor is able to give to our shelter through a simple application form and process. Last fiscal year, the donations that we received as a result of these tax credits accounted for nearly 20% of our agency budget. With changes in funding at the local, state, and federal level, the unrestricted contributions that we receive as a result of these tax credits are vital to keeping our life-saving shelter open and continue providing high-quality services as we have since 1983. When we began receiving these tax credits nearly twenty years ago, our private contributions doubled and have grown consistently since that time. Last year, we used $120,816 in tax credits and have always had to request more tax credits throughout the fiscal year in order to keep up with demand from donors. If the tax credit program were eliminated or the amount of money allocated to it were reduced, our private contributions would decrease and no longer cover the expenses that are necessary to operating a 24-hour shelter that serves 100 women and 115 children per year. We always hope that our mission and the services we provide to abused women and their children will be enough to encourage donors to give, but the tax credits are what bring some donors to our organization and certainly what enable regular donors to give more than they otherwise could have. The application form is simple, the claiming process is simple, and the staff at the Department of Social Services are extremely accessible and always helpful. Although St. Martha's Hall is appreciative that the other shelters do not use their entire allocation because it means we can double or triple our allocation of tax credits for our donors each year, we are surprised that the other shelters do not take full advantage of the program. St. Martha's Hall is infinitely grateful for this tax credit program and hope that the state government can see the value in the program and know that the rules are working to the benefit of the thousands of women and children that are able to find peace and safety as a result.

Response:

Thank you for taking the time to provide positive comments regarding regulation: 13 CSR 40-79.010. The Department of Social Services (DSS) appreciates that Domestic Violence (DV) Shelter tax credits provide additional funding for DV Shelters allowing them to provide services to those in need so they can find peace and safety. DSS also appreciates knowing the value of the DV Shelter tax credit program and will continue to provide the same customer service it does today for the tax credit program.

Comment 72

Rule: 13 CSR 40-79.010 Domestic Violence Shelter Tax Credit Program

This letter is written to provide public comment to the Department of Social Services regarding its administrative rules of the Domestic Violence Tax Credit program.

The Missouri Coalition Against Domestic and Sexual Violence (MCADSV) unites Missourians with a shared value that rape and abuse must end, and advances this through education, alliance, research and public policy. MCADSV is a statewide membership association comprised of over one hundred domestic and sexual violence agencies, many of whom rely on domestic violence tax credits.

Family Support Division: Domestic Violence Shelter Tax Credit

13 CSR 40-79.010

This rule should remain as is because it is viewed as a model tax credit program. Please see the Governor's Committee on Simple, Fair and Low Taxes report which received public comment on the domestic violence tax credits. They were highlighted as a model (page 7).

In conclusion, MCADSV appreciates having these comments taken into consideration.

Response:

Thank you for taking the time to provide positive comments regarding regulation: 13 CSR 40-79.010. The Department of Social Services (DSS) appreciates knowing the value of the Domestic Violence Shelter tax credit program and that Domestic Violence (DV) tax credits provide additional funding for DV programs.

Comment 73

13 CSR 40-79.010 Domestic Violence Shelter Tax Credit

Tax credits make a huge difference for the program. The tax credit program is handled well. The form is easy. Form is simple – donors are good with it. Also receive the NAP credit 70% - they are extremely sought after. Turnaround time on applications is great. Appreciate the quarterly reports stating the amounts of credits used to date. DV tax credit program runs well. Being patient with someone new to the program is invaluable. If DVSS payments system can be implemented for VOCA, it would be heaven for DV programs.

Response:

Thank you for submitting comments on our regulation: 13 CSR 40-79.010. The Department of Social Services (DSS) appreciates Domestic Violence (DV) tax credits provide additional funding for DV programs. DSS also appreciates knowing the domestic violence tax credit program is handled well and will continue to provide the same customer service it does today for the tax credit program.

Comment 74
13 CSR 40-79.010 Domestic Violence Shelter Tax Credit

Advocate for continuing the tax credit; how important the credits are for the services provided. Tax credits help with donor retention and help to provide funds for services to victims of abuse. The process is great and reasonable to follow. Process is a pleasure and donors are happy with process.

Response:

Thank you for submitting comments on our regulation: 13 CSR 40-79.010. The Department of Social Services (DSS) appreciates Domestic Violence (DV) tax credits provide additional funding for DV programs. DSS also appreciates knowing the process for handling the domestic violence tax credits is acceptable and will continue to provide the same customer service it does today for the tax credit program.

Comment 75
13 CSR 40-79.010 Domestic Violence Shelter Tax Credit

Tax Credits help to leverage existing resources. To Whom it May Concern: I'd like to begin by thanking you for the opportunity to comment. The Women's Safe House, founded in 1977, is the oldest and with 50-55 beds, the largest provider of emergency shelter, advocacy and transitional living services for women and children experiencing domestic violence in the St. Louis region. Last year we served 457 women and children for 13,695 bed nights. We answered 2,749 Crisis Hotline calls and turned away more than 1,000 women and children because the house was full or the location was un-safe. The Women's Safe House (TWSH) meets all the statutory requirements outlined in RSMo 455.200 and is established to provide temporary residential services to meet the basic needs of households and individuals who are victims of domestic violence. We have been an active member of the Missouri Coalition Against Domestic & Sexual Violence since 1994 and strictly adhere to its standards and quality assurance guidelines.

TWSH has participated in the Missouri Domestic Violence Tax Credit Program for many years. The program has been instrumental in assisting the agency to leverage scarce resources to support safe shelter for crime victims and meet the basic needs of some of our most vulnerable populations—women and children, fleeing from the real threat of danger and violence in the home. Those basic needs include 3 meals per day and snacks, laundry facilities on-site, intensive case management, psycho-educational group, counseling and coaching, respite services and emergency financial assistance via its economic stability program, AfterCare-a 12-month follow-up program post shelter, to prevent homelessness and re-traumatization so families can live violence-free.

The St. Louis area has some of the highest crime rates in the nation, which results in an increase in domestic abuse. Missouri Domestic Violence Tax Credits have proven invaluable in helping to provide emotional and physical safety for victims and survivors of domestic violence and in designing a comprehensive and diverse fund raising strategy. By donating cash, real property, securities, stocks and bonds, individual donors, corporations, businesses and/or shareholders have supported and helped to fund emergency shelter and shelter services, but it has also helped sustain funding. During our annual special events, particularly the annual Gala, we have seen, first hand, individual donors and corporations give more because of the availability of tax credits. In many circumstances, tax credits represent another mechanism in our state to support and work towards ending violence against women.

On behalf of The Women's Safe House Board of Directors, the staff and the thousands of women and children we have served since 1977, Thank you.

Response:

Thank you for submitting comments on our regulation: 13 CSR 40-79.010. The Department of Social Services (DSS) appreciates Domestic Violence (DV) tax credits provide additional funding for DV programs.

Comment 76

13 CSR 40-79.010 Direct Deposit of Payments

With child abuse prevention. Direct deposit of payments is a positive thing. Automation and less paperwork is always a positive. Email notification to notify payment. Know within a day or two if it will be paid. We're interested to see the upcoming changes with VOCA. VOCA funds, SSVF are received today by our organization.

Response:

Thank you for submitting comments on our regulation: 13 CSR 10-1.015. The Department of Social Services (DSS) appreciates your positive comments regarding this regulation as it was developed to help save time and costs with check processing. DSS also looks forward to the changes ahead with the VOCA program as it transitions from DPS.

Comment 77

13 CSR 45-2.010 State Technical Assistance Team (STAT)

Throughout this rule, the Division of Family Services (DFS) is referred to rather than Children's Division.

(2) Definitions

The Department of Social Services should use the same definitions for child abuse, child exploitation, child neglect and child sexual abuse consistent with 13 CSR 35-31.010 and state statute. The Department should insure all definitions in all rules are consistent

(4) (C) Add deaths in motor vehicle crashes should be added to the list of deaths reviewed by local CFRPs. CFRPs should be assessing if children who die in motor vehicle crashes are appropriately secured in child safety restraints.

(5) (C) "Other members of the state CFRP panel may include" The Department should add a representative of the Missouri Network of Child Advocacy Centers to the list of state CFRP members.

The Department should use the state CFRP to meet these roles. The state CFRP should be reviewing cases to identify systemic problems, trends and make recommendations. The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) recommended that that states should undertake a retrospective review of child abuse and neglect fatalities from the previous five years to identify family and systemic circumstances that led to fatalities. A small group of members the CFRP have initiated a review of fatalities in 2014. However, the group does not have the administrative support of STAT.

Response:

Thank you for submitting comments on STAT's regulation 13 CSR 45-2.010. A proposed amendment has been drafted and is awaiting approval that addresses your comments. The amendment updates the name of Children's Division from the Division of Family Services. The definitions of child abuse, child exploitation, child neglect, and child sexual abuse have been removed in the amendment. Vehicular injury is now a factor that, if present, will enable the local Child Fatality Review Panel to review a death of a child less than eighteen years of age. Members of the state CFRP panel may include persons from "Any other professionals or citizens with special interest in child abuse and neglect." This broader language gives more flexibility to naming members of the panel, rather than naming specific groups. STAT prioritizes the resources provided by the general assembly to meet its responsibility to assist local CFRP panels in investigating and prosecuting cases involving child abuse, child neglect, child sexual abuse, child exploitation, or child fatality review.

Comment 78

13 CSR 45-2.010 State Technical Assistance Team (STAT)

Remove DFS – child fatality – CFRP MoNet work is all local level. STAT – child fatality repeal – don't study cases? Identify systems problems. CFRP did in 2014 need admin support (case copies)

Throughout this rule, the Division of Family Services (DFS) is referred to rather than Children's Division.

(2) Definitions: The department of Social Services should use the same definitions for the child abuse, child exploitation, child neglect and sexual abuse consistent with 13 CSR 35-31.010 and state statute. The Department should insure all definitions in all rules are consistent.

(4)(C) Add deaths in motor vehicle crashes should be added to the list of deaths reviewed by local CFRP's. CFRP's should be assessing if children who die in motor vehicle crashes are appropriately secured in child safety restraints.

(5)(C) "Other members of the state CFRP panel may include" The Department should add a representative of the Missouri Network of Child Advocacy Centers to the list of state CFRP members.

The Department should use the state CFRP to meet these roles. The state CFRP should be reviewing cases to identify systemic problems, trends and make recommendations. The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) recommended that states should undertake a retrospective review of child abuse and neglect fatalities from the previous five years to identify family and systemic circumstances that led to fatalities A small group of members the CFRP have initiated a review of fatalities in 2014. However, the group does not have the administrative support of STAT.

Response:

Thank you for submitting comments on STAT's regulation 13 CSR 45-2.010. A proposed amendment has been drafted and is awaiting approval that addresses your comments. The amendment updates the name of Children's Division from the Division of Family Services. The definitions of child abuse, child exploitation, child neglect, and child sexual abuse have been removed in the amendment. Vehicular injury is now a factor that, if present, will enable the local Child Fatality Review Panel to review a death of a child less than eighteen years of age. Members of the state CFRP panel may include persons from "Any other professionals or citizens with special interest in child abuse and neglect." This broader language gives more flexibility to naming members of the panel, rather than naming specific groups. STAT prioritizes the resources provided by the general assembly to meet its responsibility to assist local CFRP panels in investigating and prosecuting cases involving child abuse, child neglect, child sexual abuse, child exploitation, or child fatality review.

Comment 79
13 CSR 45-2.010 State Technical Assistance Team (STAT)

(4) (C) Add children that die as a result of a motor vehicle crash to the list of those to be reviewed by the Child Fatality Review Panel. These deaths should be reviewed for safety restraint use or children that may have been deceased prior to a crash.

(5) (C) "Other members of the state CFRP panel may include" The Department should add a representative of the Missouri Network of Child Advocacy Centers to the list of state CFRP members.

Response:

Thank you for submitting comments on STAT's regulation 13 CSR 45-2.010. A proposed amendment has been drafted and is awaiting approval that addresses your comments. In the amendment, vehicular injury is now a factor that, if present, will enable the local Child Fatality Review Panel to review a death of a child less than eighteen years of age. Members of the state CFRP panel may include persons from "Any other professionals or citizens with special interest in child abuse and neglect." This broader language gives more flexibility to naming members of the panel, rather than naming specific groups.

Comment 80
13 CSR 45-2.010 State Technical Assistance Team (STAT)

"DFS" has not existed for many years. For clarity and consistency, the verbiage should be changed to Children's Division.

(2) Definitions are not consistent throughout statutes. The Department of Social Services should use the same definitions for child abuse, child exploitation, child neglect and child sexual abuse consistent with 13 CSR 35-31.010 and state statute.

(5) (C) Regarding the members listed on the Child Fatality Review Panel, DSS should consider adding a representative of the Missouri Network of Child Advocacy Centers to the list of state CFRP members.

Under "B" the State CFRP should be reviewing cases to identify systemic problems, trends and make recommendations. The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) recommended that states should undertake a retrospective review of child abuse and neglect fatalities from the previous five years to identify family and systemic circumstances that led to fatalities. A small group of members the CFRP have initiated a review of fatalities in 2014. However, the group does not have the administrative support of STAT.

Response:

Thank you for submitting comments on STAT's regulation 13 CSR 45-2.010. A proposed amendment has been drafted and is awaiting approval that addresses your comments. The amendment updates the name of Children's Division from the Division of Family Services. The definitions of child abuse, child exploitation, child neglect, and child sexual abuse have been removed in the amendment. Vehicular injury is now a factor that, if present, will enable the local Child Fatality Review Panel to review a death of a child less than eighteen years of age. Members of the state CFRP panel may include persons from "Any other professionals or citizens with special interest in child abuse and neglect." This broader language gives more flexibility to naming members of the panel, rather than naming specific groups. STAT prioritizes the resources provided by the general assembly to meet its responsibility to assist local CFRP panels in investigating and prosecuting cases involving child abuse, child neglect, child sexual abuse, child exploitation, or child fatality review.

Comment 81

13 CSR 45-2.010 State Technical Assistance Team (STAT)

Throughout this rule, the Division of Family Services (DFS) is referred to rather than Children's Division.

(2) The Department of Social Services should use the same definitions for child abuse, child exploitation, child neglect and child sexual abuse consistent with 13 CSR 35-31.010 and state statute. The Department should insure all definitions in all rules are consistent.

(4) (C) Add deaths in motor vehicle crashes should be added to the list of deaths reviewed by local CFRPs. CFRPs should be assessing if children who die in motor vehicle crashes are appropriately secured in child safety restraints.

(5) (C) "Other members of the state CFRP panel may include" The Department should add a representative of the Missouri Network of Child Advocacy Centers to the list of state CFRP members.

The Department should use the state CFRP to meet these roles. The state CFRP should be reviewing cases to identify systemic problems, trends and make recommendations. The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) recommended that states should undertake a retrospective review of child abuse and neglect fatalities from the previous five years to identify family and systemic circumstances that led to fatalities. A small group of members the CFRP have initiated a review of fatalities in 2014. However, the group does not have the administrative support of STAT.

Response:

Thank you for submitting comments on STAT's regulation 13 CSR 45-2.010. A proposed amendment has been drafted and is awaiting approval that addresses your comments. The amendment updates the name of Children's Division from the Division of Family Services. The definitions of child abuse, child exploitation, child neglect, and child sexual abuse have been removed in the amendment. Vehicular injury is now a factor that, if present, will enable the local Child Fatality Review Panel to review a death of a child less than eighteen years of age. Members of the state CFRP panel may include persons from "Any other professionals or citizens with special interest in child abuse and neglect." This broader language gives more flexibility to naming members of the panel, rather than naming specific groups. STAT prioritizes the resources provided by the general assembly to meet its responsibility to assist local CFRP panels in investigating and prosecuting cases involving child abuse, child neglect, child sexual abuse, child exploitation, or child fatality review.

Comment 82

13 CSR 70-1.010 Organization and Description

I'm not sure where to comment on this particular rule but if the rule could be re-written to include that LCSWs, LMSWs, LPC, and PLCPCs (mid-level providers) can see adults for Behavioral Health services. We receive a numerous amount of adult referrals that we are unable to accept because our providers are considered mid-level providers. It really would open up a lot of access to adults for quality behavioral health services. Can someone please use this comment and really evaluate the FFS Access for adults for behavioral health needs as I know that is something currently that is being examined. I really believe this would make a huge difference for members and access to providers. In addition, there was a waiver being worked on that would allow mid-level practitioners to see adults ages 21-35 as that age group was identified as a risk. I have not seen anything come through so I believe Mo Health Net is still working on this waiver. Thank you very much for considering my comments!

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-1.010. MO HealthNet participants receive Behavioral Health

services through the State Plan. The MO HealthNet Division (MHD) examines behavioral health needs for all MO HealthNet participants. The MHD monitors for access in compliance with the Access Monitoring Review Plan requirements. The MHD appreciates the comment and as a result will evaluate the inclusion of the additional mental health practitioners to provide services to the adult population.

Comment 83
13 CSR 70-1.010 Organization and Description

Comment #1 Requiring Higher Standards than National Committee for Quality Assurance (NCQA) Standards

REQUIREMENT: 13 CSR 70-1.010.E.1 (general requirement)

"Managed Care. This unit is responsible for administration of the MC+ Managed Care Program which operates under a 1915(b) Freedom of Choice Waiver. This program provides Medicaid Managed Care services to recipients in four (4) broad groups: Medical Assistance for Families, Medicaid for Children, Medicaid for Pregnant Women, and children in state custody. This unit is also responsible for developing new policies and procedures for the MC+ Managed Care Program."

COMMENT: NCQA is a national recognized organization that requires health plans to meet certain standards to obtain NCQA accreditation. NCQA accreditation is also required by health plans contracted with the Missouri HealthNet Division to meet these standards. As health plans work to provide quality health care at a lower cost, alignment with these already high standards would assist in: 1) providing consistent services when able to leverage similar processes and systems, and 2) reducing additional administrative resources while still complying with industry recognized quality standards. We understand there may be specific situations when higher standards may be implemented; however, these variances should consider the additional administrative resources to implement specific processes, conduct additional training and education, increasing staffing, create specific reporting, and oversee compliance with the specific requirement. We request the state consider alignment with NCQA standards to reduce administrative burden and ultimately reducing taxpayer funds while maintaining requirements of meeting a nationally recognized standard.

Comment #2:

REQUIREMENT

19 CSR 10-5.010(3)(C)

"(C) Each licensed health care plan shall submit separate quality indicator data files for their commercial, Medicaid and Medicare enrollees. ~~Health care plans that contract with the Division of Medical Services to provide coverage in more than one Medicaid region, shall submit separate quality indicator data for the enrollees in each region.~~ The quality indicator data shall be submitted to the department in electronic form and conform to the specifications listed in Table B. Table B is included herein." …

"Table B..

File Consistency

Plans that elect to submit separate files for sub-groups of their enrollment population must consistently do so for all data submission categories required by this rule. ~~Health care plans that contract with the Division of Medical Services to provide coverage in more than one Medicaid region, shall submit separate quality indicator data for the enrollees in each region~~."

COMMENT: Recommendation is to remove the requirement that reporting metrics be provided by region (recommendations above). This requirement is greater than National Council of Quality Assurance (NCQA) standards and result in additional complexity and administrative burden.

Comment #3

REQUIREMENT: 13 CSR 70-1.010.E.1

"Managed Care. This unit is responsible for administration of the MC+ Managed Care Program which operates under a 1915(b) Freedom of Choice Waiver. This program provides Medicaid Managed Care services to recipients in four (4) broad groups: Medical Assistance for Families, Medicaid for Children, Medicaid for Pregnant Women, and children in state custody. This unit is also responsible for developing new policies and procedures for the MC+ Managed Care Program."

COMMENT 3a: Report and Performance Metric Guidance

MO HealthNet requires managed health care organizations to provide various performance oversight reports to MO HealthNet in monitoring performance and also to determine if certain performance metrics allow for funds to be withheld and retained if the managed care plans do not meet certain performance standards. Currently, formal guidance has not been provided for many of the reports and metric calculations. The recommendation is for the state to require specific guidance with examples on how the performance metrics are calculated, specifically metrics that impact withholding or releasing funds. Without clear expectations, manage care organizations likely have different interpretations of how reports are produced and metrics calculated and has caused administrative burdens when verbal discussions and expectations vary from the final determination, especially with performance to be met on a contract that was effective on May 1, 2017. This has and will likely continue to result in varying interpretations and cause disagreements resulting in appeals that are administratively burdensome to not only managed care organizations but also to state resources and tax payer dollars.

COMMENT3b: Member Communication and Marketing Material Pre-approval

Recommendation is to provide guidance that requires specific member communications and advertising/marketing materials to be approved by MO HealthNet and allow other non-significant communications to be tracked and the applicable documentation retained for review of regulatory compliance

requirements. Potential alternatives to continue to allow visibility of non-significant communications while lowering administrative burdens include periodic reporting of non-significant communications or a "file and use" process.

MO HealthNet currently requires all managed care member materials, communications, advertising and marketing to be submitted for review and approval and provide 30 days for review by MO HealthNet. We understand the need to review and approve key member communications and marketing materials (e.g., explanation of coverage, member handbook, authorization determination, identification cards, etc.) and this is generally required in many states and federal programs; however, most pre-approval communications relate to information that we would not consider key communications and do not require approval in many states or do not require the level of documentation required today. A few member communication examples that require MO HealthNet pre-approval include children's books on healthy behaviors (brushing teeth, eating healthy foods, living with asthma, etc.), providing phone apps from national vendors that provide quick access to new mom resources (nurse advice line, lactation consultant, etc.), education from nationally recognized organizations (CDC, NIH, American Heart Association, American Diabetes Association, etc.), and member authorized text message reminders (appointments, healthy behavior education, etc.).

As to the level of documentation required, the pre-approval submission process requires individual documentation submission of each communication (e.g., each text message wording variation, each phone application page, each education on various conditions and recommendations). This documentation must also be in "camera ready" form that causes additional resources to obtain and format and also has its own challenges. A couple examples include challenges in providing a social media posting when "camera ready" requires posting the information externally to obtain the "camera ready" view, and also providing "camera ready" formats for systems that still require resources to build or customize (e.g., phone or computer applications). The result is an increase in resources by managed care organizations but also MO HealthNet to manage the review and approval process. It also results in new technology or innovative methods not being considered due to the administrative burden to submit for approval.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-1.010. The MO HealthNet Managed Care health plans are required to be accredited by the NCQA. The Managed Care health plans are evaluated on how well the health plans manage all parts of their delivery system. The NCQA standards focus on quality of care and quality improvement. The MHD does take into consideration NCQA standards for a variety of areas that NCQA evaluates. The MHD maintains the flexibility to require more stringent or different standards when in the interest of the quality of the Managed Care Program or when required by state or federal law or regulation.

The MHD has provided oral and written instructions, explanations, expectations, and guidance regarding how performance metrics are calculated to the Managed Care health plans. The MHD conducted meetings and work groups

with the Managed Care Organizations to collaborate on the future Performance Withhold Program. The MHD intends to issue further written guidance.

The MHD is required by federal regulation to monitor and regulate the Managed Care health plans' marketing and member materials. The MHD has taken action to reduce the types of materials that require review, streamlining the review process, and seeking resources to procure an automated system.

Your comment #2, which pertains to 19 CSR 10-5.010(3)(C) has been sent to the Department of Health and Senior Services because it is a DHSS regulation.

Comment 84

13 CSR 70-3.020 Title XIX Provider Enrollment

I disagree with this rule!!

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-3.020.

Comment 85

13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for MO HealthNet Services

This is in response to the QA/Personnel Advisory Board and Division of Personnel Regulation Review e-mail.

I currently deal with the following regulations, RSMO's and Manuals on a regular basis:

19 CSR 15-7.021, In-Home personal care regulation, Department of Health and Senior Services (DHSS)

19 CSR 14-8.400, Consumer Directed Services (CDS), DHSS

19 CSR 15-9.100, Electronic Visit Verification (EVV), DHSS

19 CSR 30-82.060 Hiring Restrictions-Good Cause Waiver, DHSS RSMO 192.2495, Family Care Safety Registry (FCSR), DHSS RSMO 192.2400, Employee Disqualification List, DHSS

13 CSR 70-91.010, Personal Care Program, Mo HealthNet (MHD)

13 CSR 70-3.030, Sanctions for False or Fraudulent Claims for MO HealthNet Services, MHD

Personal Care Manual, MHD

Aged and Disabled Waiver Manual, MHD

Adult Day Care Waiver Manual, MHD

I will try to address a few regulation/program concerns because I'm sure you do not want a book and most of what I have to say has already been said by someone else. Hopefully I can reinforce what you already know. My approach is not that of a public servant who deals with the Home and Community Based Services (HCBS) program every day, but also a tax payer and someone who's interested in participant safety and provider compliance.

Regulations 19 CSR 15-7.021 and 13 CSR 70-91.010 both deal with the In-Home program but disagree on some points. I believe there is some talk about 13 CSR 70-91.010 going away, this would be great. 19 CSR 15-7.021 needs to be

updated. Section (4) (A) 4, (18) (C), (19) (G) and (24) (D). Providers should not have to screen aides because each aide should have to enroll and have a number. State could screen the aide when he/she enrolls. This would save the provider time in screening and would ensure the screening is completed. Currently some providers fail to complete the screening or do not complete it timely so we have unscreened aides serving participants. Some of these aides have very serious charges against them. Also when the services are billed MHD, the claim would have the aide's number on it. This would help in the audit process if money needed to be recouped. Also, if needed, the aide could be disenrolled. In the current system it's easy for bad aides to jump from provider to provider. I know some states currently have a system that enrolls the aide. We would need some type of system to enable providers to easily check aide enrollment. Having aides enrolled and screened by the state would not only save providers time, it would make the screening the same for everyone. Currently personal care employees in an RCF/ ALF only apply for Good Cause Waiver (GCW) if they have a finding that's a crime against persons. In-Home aides and CDS attendants have to apply for a GCW for any finding. In the Adult Day Care program, they have to check the EDL every 90 days. Presently the In-Home employees and CDS attendants are only required to be screened at time of employment. So, you could hire on as an aide, pass the screening, and go sell drugs and steal, call in sick on days you have court, and keep right on working.

Section (5) addresses the proposal process. Currently you can go on line, buy the proposal, fill your company name in the correct blanks and submit it to MMAC. Today you're flipping hamburgers and tomorrow you're an In-Home or CDS provider. Most people would think this was a success story. It has not been a success for the Medicaid system or participants. The majority of these providers have not read the regulations and do not know how to run a business. Because of this, we have fraud issues and participant care issues. A person wanting to be a provider needs some type of professional training. Some type of medical and business training would be great. Maybe it should be required they be an RN or have a business degree.

Section (18) (S) and (T) is really outdated.

Section (21) (B) Should be removed. Why should the provider have to report it if only 80% of the services are being delivered?

All aide training needs to be updated because a lot of things have changed in Health Care since this regulation was written. Should have the provider organizations submit improved training plans for the state to review and incorporate the best ideas into the new regulation.

Going back to the Proposal Process for a minute: It should be in the regulation that providers have to have a commercial business office. This would solve a lot of problems. I will mention only one. Handicap accessibility is checked on the pre-site-visit for In-Home and CDS providers that are in the proposal process. Most of the time, a rent- a-ramp is on the front stairs of the provider's home with the storm door propped open. Of course, this ramp comes off as soon as the state employee leaves.

CDS regulation 19 CSR 15-8.400: before I address a few things in this regulation, I believe we should have one way to receive HCBS services. The CDS program is an extremely fraudulent program. I'm told the FEDS (CMS) are "in love" with this program. Someone may need to educate them. The initial idea may be good (having family taking care of family) but it opens the door for fraud. We have seen instances where the attendant and consumer worked to fraud the system. Time sheets were completed and signed but no services were provided. The money was split between the consumer and attendant. In some cases, the provider had the consumer sign the time sheet, and the provider and consumer split the money. The attendant was working another full-time job, and documenting providing service in the same time period. It has been promoted as an employment plan. These are just a few issues. Our Medicaid system would be in better shape if we had one way to receive services and it was the In-Home model with a few changes. Expand transportation and what hours services are provided. Currently most In-Home providers do not provide service after 5 P.M. Some of the younger participants may need service a little later in the day. Having the aide/attendant work for an agency works a lot better than having the attendant work for the consumer. No relatives should work for relatives and the agency should do the training and have oversite of the employee. If the program has to stay, I want to touch on a few changes. 19 CSR 15-8.400 (4) (A) 1. Would be removed because the state would be completing the screening when the attendant is enrolled. (4) (F) all case management needs to be a monthly, unannounced visit in the consumer's home. CDS Providers need to attend a yearly state training. (7) (G) and (H) I would discontinue quarterly reports and (J) the annual audit. The state can get a little information off of the quarterly reports but we spend more in man hours than the information we receive is worth. The annual audit costs the provider a lot of money, and serves no great purpose to the state. The annual audit is a burden to small providers. In-Home providers are not required to provide quarterly reports or annual audits. Providers that provide In-Home-service are required to give 21-day notice when discontinuing service; this also needs to be added to CDS. Under 19 CSR 15-8.100 Definitions (1) (C) it states "Consumer does not include any individual with a legal limitation of his or her ability to make decisions, including the appointment of a guardian or conservator, or who has an effective power of attorney that authorizes another person to act as the agent or on behalf of the individual for any of the duties required by the CDS program:". But today we have consumers receiving CDS that have a POA, etc. What makes this even worse is that some of the POA's are the care givers signing the timesheets for the participants. In St. Louis, we have an over flow of CDS providers. We have so many providers that the state is promoting fraud. What I mean by "promoting fraud" is we have a limited number of participants and an over flow of CDS providers wanting to attract those participants any way they can. This is not a good environment for small business or consumers. No one would lose service if a state-wide moratorium was put in place. I know the state has talked to CMS about this, but this really needs to happen.

19 CSR 15-9.100, Electronic Visit Verification: I would do away with this regulation and insert the language into the other regulations. This regulation had some of the teeth removed before the ink was dry. The intent was that all providers would document tasks but the CDS providers got by with documenting the five or six categories they documented on paper timesheets. Also for EVV to work correctly, we must stop using the participant's phone. Currently we have a big issue with government phones. On most participant government phones, they have 400 minutes a month. If the provider uses 5 minutes a day on a 30 day month they will use 150 minutes. Participants can refuse to let the aides use their phone. It's time the EVV requirement is moved away from the phone to other technologies.

The final In-Home regulation needs to have language that applies specifically to personal care delivered in an RCF/ ALF. When in a facility around the clock with two or three shifts, it changes the way things are documented. I believe they are mandated to have EVV by 2019 so this should be included in their part of the regulation. Some call this the "double dip program" because the RCF/ALF is being paid by a relative, or taking the person's Social Security check, etc. so personal care services are provided. But the state, through the personal care program, pays the RCF/ ALF again for these services. This provider type receives roughly eight million dollars a year.

Day Care Regulation: You notice I have no number. This is because MHD has no regulation for this program. The audit agency is told we have the Licensure and Regulation, Adult Day Care Waiver Manual and Aged and Disabled Waiver Manual and we do not need a regulation. But we have no regulation on what we are going to audit. The other problem is that a manual does not hold up when in appeal at the AHC.

We need strong language in every regulation concerning the loss of services for the participant, and loss of being a provider if fraud is committed. Having this as the Sanction regulation is great but it really needs to be enforced by other regulation also. This is not meant to sound hard nosed or uncaring, but we must protect the taxpayer money and I believe at some point most taxpayers would say "no" to fraud.

A few other issues and I will close.

Mental Health-The state pours a lot of money into these programs and the money rolls out without proper oversight. Once again, we have family members getting paid to take care of family members. My heart goes out for anyone that has a disabled child, but something is wrong when these families have a better income off of Medicaid than most taxpayers. Also MMAC enrolls the state's 56,000 Medicaid providers but not Mental Health providers. If my memory serves me right, they have 12 regions across the state but the rules differ between each region.

Reassessments for HCBS services-Paying the providers to complete reassessment is a poor system. I understand DHSS needed a quick solution. We have nothing in regulation regarding this process. This is one place where we need an outside vendor to do these reassessments. I know last time it did not work out,

but we need to try again. I'm really concerned that if the LOC goes to 24 points, we will still have the previous 21 LOC participants on services.

Most of the HCBS providers are honest and care for the participants they serve, but we need to give them good guidance and weed out the fraudulent providers.

Of course, any changes in these rules will cause a firestorm. We have providers that bill Medicaid over 20 million dollars a year for the services I discussed above. Many of these providers also provide and bill Medicaid for Home Health, Hospice and Mental Health services.

They are not afraid to protect their interests.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-3.030. In reviewing the comments, the MHD continues to work with other departments and across department divisions to ensure participant safety and provider education. The MHD commits to this coordination as an on-going process to continually improve the MHD regulations.

Comment 86

13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for MO HealthNet Services

13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for MO HealthNet Services

42. Billing for the same service as another provider when the service is performed or attended by more than one (1) enrolled provider. MO HealthNet will reimburse only one (1) provider for the exact same service;

Suggest adding an exception when personal care services are performed under the Personal Care Program either prior to or after admission/discharge of the other enrolled provider.

(5) Imposition of a Sanction.

(A) The decision as to the sanction to be imposed shall be at the discretion of the MO HealthNet agency. The following factors shall be considered in determining the sanction(s) to be imposed:

6. Actions taken or recommended by peer review groups, licensing boards, or Professional Review Organizations (PRO) or utilization review committees—Actions or recommendations by a provider's peers shall be considered as serious if they involve a determination that the provider has kept or allowed to be kept, substandard medical records, negligently or carelessly performed treatment or services, or, in the case of licensing boards, placed the provider under restrictions or on probation.

Recommend utilizing the peer review groups in order to be more cost effective and combine state and industry knowledge and perspective by working cohesively for the better clarification/interpretation of the review process prior to any imposition of sanctions.

(C) When a sanction involving the collection, recoupment, or withholding of MO HealthNet payments from a provider is imposed on a provider, it shall become

effective ten (10) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction

Suggest adding unless under challenge by the provider.

When any other sanction is imposed on a provider it shall become effective thirty (30) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction

Suggest adding unless under challenge by the provider.

If, in the judgment of the single state agency, the surrounding facts and circumstances clearly show that serious abuse or harm may result from delaying the imposition of a sanction, any sanction may be made effective immediately upon receipt of notice by the provider.

Suggestions are to improve and accomplish a more streamlined, cost-effective approach and process.

13 CSR 70-3.180 Medical Pre-Certification Process

(1) Providers are required to seek pre-certification for certain specified services listed in the provider manuals, provider bulletins, or clinical edits criteria before delivery of the services. This rule shall apply to diagnostic and ancillary procedures and services listed in the provider manuals, provider bulletins, or clinical edits criteria when ordered by a healthcare provider unless provided in an inpatient hospital or emergency room setting. This pre-certification process shall not include primary services performed directly by the provider. In addition to services and procedures that are available through the traditional medical assistance program, expanded services are available to children twenty (20) years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require pre-certification. Certain services require pre-certification only when provided in a specific place or when they exceed certain limits. These limitations are explained in detail in subsections 13(3) and 14(4) of the applicable provider manuals, provider bulletins, or clinical edits criteria, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO. HealthNet Division, 615 Howerton Court, Jefferson

Add: Personal Care Services is considered custodial care there forth a denial is not required.

5.4 COMMERCIAL MANAGED HEALTH CARE PLANS

Employers frequently offer commercial managed health care plans to their employees in an effort to keep insurance costs more reasonable. Most of these policies require the patient to use the plan's designated health care providers. Other providers are considered "out-of-plan" and those services are not reimbursed by the commercial managed health care plan unless a referral was made by the commercial managed health care plan provider or, in the case of emergencies, the plan authorized the services (usually within 48 hours after the service was provided). Some commercial managed care policies pay an out-of-plan provider at a reduced rate. At this time, MO HealthNet reimburses providers who are not affiliated with the commercial managed health care plan. The provider must attach a denial from the commercial managed-care plan to the MO HealthNet

claim form for MO HealthNet to consider the claim for payment. Frequently, commercial managed health care plans require a copayment from the patient in addition to the amounts paid by the insurance plan. MO HealthNet does not reimburse copayments. This copayment may not be billed to the MO HealthNet participant or the participant's guardian caretaker. In order for a copayment to be collected the parent, guardian or responsible party must also be the subscriber or policyholder on the insurance policy and not a MO HealthNet participant.

4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY

Claims for participants who have other insurance must first be submitted to the insurance company in most instances. Refer to Section 5 for exceptions to this rule. However, the claim must still meet the MO HealthNet timely filing guidelines outlined above. (Claim disposition by the insurance company after 1 year from the date of service does not serve to extend the filing requirement.) If the provider has not had a response from the insurance company prior to the 12-month filing limit, they should contact the Third Party Liability (TPL) Unit at (573) 751-2005 for billing instructions. It is recommended that providers wait no longer than 6 months after the date of service before contacting the TPL Unit. If the MO HealthNetDivision waives the requirement that the third-party resource's adjudication must be attached to the claim, documentation indicating the third-party resource's adjudication of the claim must be kept in the provider's records and made available to the division at its request. The claim must meet the MO HealthNet timely filing requirement by being filed by the provider and received by the state agency within 12 months from the date of service.

5.7 THIRD PARTY LIABILITY BYPASS

There are certain claims that are not subjected to Third Party Liability edits in the MO HealthNet payment system. These claims are paid subject to all other claim submission requirements being met. MO HealthNet seeks recovery from the third party resource after MO HealthNet reimbursement has been made to the provider. If the third party resource reimburses MO HealthNet more than the maximum MO HealthNet allowable, by federal regulation this overpayment must be forwarded to the participant/policyholder. The provider may choose not to pursue the third party resource and submit a claim to MO HealthNet. The provider’s payment is limited to the maximum MO HealthNet allowable. The following services bypass Third Party Liability edits in the MO HealthNet claims payment system:

- The claim is for personal care or homemaker/chore services.
- The claim is for adult day health care. The claim is for intellectually disabled/developmentally disabled (ID/DD) waiver services.
- The claim is for a child who is covered by a noncustodial parent’s medical support order.
- The claim is related to preventative pediatric care for participants under age 21 and the preventative service is the primary diagnosis on the claim.
- The claim relates to prenatal care for pregnant women and has a primary diagnosis of pregnancy or has one of the following procedure codes listed:

59400 Global Delivery—Vaginal

59425, 59426 G l o b a l Prenatal
59510 Global Cesarean

Recommendation – for continuity of processes for all managed care providers, suggest the state review and understand the manual references.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-3.030. In regard to the suggestion that the MHD add an exception for Personal Care Services, the MHD does not reimburse for duplicative billing. In order to protect against duplicate billing, the MHD reimburses only one provider for the exact same service. If the services are not duplicative, the provider should contact the MHD Provider Communications at (573) 751-2896 to request a review of the denied claims.

The MHD utilizes peer review groups and is currently in the process of incorporating additional peer review groups.

Adding the suggested statement to the MHD regulation that the sanction effective dates and timeframes should not apply when the sanction is challenged by the provider would be duplicative of the already established Administrative Hearing Commission (AHC) regulation.

The MHD needs further clarification concerning the suggestion to include a statement that Personal Care Services (PSC) are considered custodial care and a denial is not require. The MHD would welcome clarification concerning the suggested changes to the MHD regulation.

The MHD appreciates the additional comments and is currently reviewing the manual references, 4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY, 5.4 COMMERCIAL MANAGED HEALTH CARE PLANS, and 5.7 THIRD PARTY LIABILITY BYPASS, suggested in the comments.

Comment 87

13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services

The purpose of this memorandum is to propose amendments, deletions, and other changes to existing rules and regulations of the Missouri Department of Social Services that are currently negatively impacting providers and recipients of long term care. Under Governor Greitens' 'no more red tape' initiative and Executive Order 17-03, all agencies must accept written public comments for review for at least a sixty day period. The Missouri Department of Social Services extended its deadline to submit comments to October 15, 2017. This memorandum is being sent on behalf of the Missouri Health Care Association (MHCA) and it contains the written comments that MHCA would like considered by the Missouri Department of Social Services during its rule review.

Many of the regulations most burdensome to long term care facilities are federal, and others are under the Missouri Department of Health and Senior Services. However, the below changes to the following policies, rules, and regulations administered by the Department of Social Services would be very helpful to long term care stakeholders. The suggestions below are aimed at

increasing transparency in government, efficiency in government and long term care facilities, and improving the health, safety, and welfare of Missourians.

- 13 CSR 70-10.015 (4)(J) –(l), (7)(c), (11)(D)1.A.(III – (IV), (13)(B)(6) and (20)(H); Facility Remodels: Current regulations found at 13 CSR 70-10.015 (4)(J) – (l), (7)(c), (11)(D)1.A.(III – (IV), (13)(B)(6) and (20)(H) read together do not provide a nursing facility the ability to recover fully its costs for improvements to its facility outside of the addition of beds. This prevents older, but useful and otherwise adequate facilities from improving their technology and physical infrastructure to better meet the needs of their residents. As a result, the regulations promote the construction of brand new facilities whose Medicaid per diem reimbursement rates calculated under the same regulation will be higher than those of existing facilities. Not only does this cost the Medicaid program more for the same service (long term care), but results in over-bedding in the market place and exacerbates the existing shortage of qualified personnel to care for the residents. Modification of the aforementioned sections of 13 CSR 70-10.015 to allow existing facilities to recover their capital and other costs of making allowable improvements to their physical plant and other permanent infrastructure through a rate adjustment process will therefore benefit both the Medicaid Program as well as the facilities and their residents while stabilizing the workforce situation for this post-acute sector.
- Student Loan Impact on Medicaid Qualification: When calculating Medicaid eligibility, garnishments (*e.g.*, child support) are typically counted against income and/or assets for purposes of determining if an individual qualifies. If possible, student loan payment amounts should also count against income and/or assets for purposes of Medicaid eligibility determinations for all categories of covered individuals (*e.g.*, seniors, pregnant women, and individuals with disabilities).

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-10.015. The MHD appreciates the comments regarding the modification of the mentioned sections of 13 CSR 70-10.015 and is analyzing this suggestion for consideration.

The Family Support Division (FSD) is responsible for determining Medicaid eligibility. The student loan reimbursements are not counted as income and student loan payments are not deducted from income. However, there are certain populations which have allowable deductions for student loan interest. Please refer to CFR 42 CFR 431, 433,435 and 457 for allowable income deductions.

Comment 88

13 CSR 70-35.010 Dental Benefits and Limitations, MO HealthNet Program

Start over on the application; it is a disaster. The form is the worst I have ever seen. It does not save, edit, etc at all. The information is formatted SO THAT IT IS NOT USER FRIENDLY, and THE QUESTIONS ARE NOT EVEN RELEVANT, OR CONTAIN THE DETAIL OF THE SITUATION. I WANT THIS FORM REPLACED.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-35.010. The MHD appreciates the feedback concerning the information and user ability of the form. The Prior Authorization (PA) form is the form referenced in 13 CSR 70-35.010. When PA is required, the PA form provided by MHD is a standardized form applicable to all MO HealthNet programs for PA requests. The MHD will consider reviewing the PA form to update pertinent information and ease of use.

Comment 89

13 CSR 70-40.010 Optical Benefits and Limitations—MO HealthNet Program

REPLACE THIS FORM, NOT USER FRIENDLY. Does specify additional information, etc. hard to read, will not save.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-40.010. 13 CSR 70-40.010 does not mention any form or requirements to use a form. The MHD welcomes clarification concerning the form in which the commenter is referencing.

Comment 90

13 CSR 70-50.010 Hospice Services Program

I understand you have called for a rule review for all agencies. In the Rules of Social Services, Div 70 ch 50 it states that attending physicians in hospice are MD or DO. CMS says APRN's can be attending physicians. Though this rule is truly written only for MO HealthNet patients, in MO it is frequently counted for ALL hospices and ALL NP's. This rule is in direct conflict with CMS and causes barriers to care for many patients. This statement in the rules needs to be removed.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-50.010. The MHD does not currently restrict participants from choosing an Advanced Practice Registered Nurse (APRN) as their attending physician for hospice services.

Comment 91

13 CSR 70-55.010 MO HealthNet Program Benefits for Nurse-Midwife Services

Rules for nurse midwives currently restrict the choice of women in Missouri regarding their location of birth. Nurse-midwives in Missouri specialize in safe birth in community settings, including birth centers and home birth, in addition to hospital-based birth. Current medicaid rules in Missouri prohibit home birth without any legitimate rationale. The restriction against home birth by licensed professionals who are integrated into the healthcare system, such as Certified Nurse Midwives, leads women to choose potentially unsafe birth practices, such as birthing without professional assistance or hiring an unlicensed provider for

assistance, who may lack resources for care within the greater health system should an emergency arise, and who may not provide prenatal care that meets national standards. Birth centers are approved for a place of birth, and research shows that when women are screened appropriately and when a qualified professional is present, home birth is identical to a birth center in safety for women. There is no benefit to the state in restricting the place of birth, it only increases risk to women. I would be glad to present any evidence needed to help resolve this issue.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-55.010. The MHD currently reimburses Nurse Midwives for home births through the Fee-for-Service (FFS) program. If applicable to the participant's eligibility, the MHD will reimburse for delivery in the office, birthing center, hospital, and home. If the participant is enrolled in a managed care plan and elects a home birth, the participant must be disenrolled from the managed care program and receive all services through the FFS program.

Comment 92

13 CSR 70-55.010 MO HealthNet Program Benefits for Nurse-Midwife Services

It makes no sense to restrict access to care for women seeking out of hospital birth. Making a different choice should not be punished.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-55.010. The MHD currently reimburses Nurse Midwives for home births through the Fee-for-Service (FFS) program. If applicable to the participant's eligibility, the MHD will reimburse for delivery in the office, birthing center, hospital, and home. If the participant is enrolled in a managed care plan and elects a home birth, the participant must be disenrolled from the managed care program and receive all services through the FFS program.

Comment 93

13 CSR 70-55.010 HealthNet Program Benefits for Nurse-Midwife Services

All women in state of missouri should have the right to have a home birth or at a birthing center not inside a hospital. As long as they have a safe provider there is no logical reason why women should be denied through Medicaid.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-55.010. The MHD currently reimburses Nurse Midwives for home births through the Fee-for-Service (FFS) program. If applicable to the participant's eligibility, the MHD will reimburse for delivery in the office, birthing center, hospital, and home. If the participant is enrolled in a managed care plan and elects a home birth, the participant must be disenrolled from the managed care program and receive all services through the FFS program.

Comment 94
13 CSR 70-55.010 MO HealthNet Program Benefits for Nurse-Midwife Services

There is no logical reason to restrict the choice of Missouri women to have a home birth with a safe provider. ALL women, including those on Medicaid, deserve the right to choose their place of birth, and should not lose their benefits if they plan a home birth.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-55.010. The MHD currently reimburses Nurse Midwives for home births through the Fee-for-Service (FFS) program. If applicable to the participant's eligibility, the MHD will reimburse for delivery in the office, birthing center, hospital, and home. If the participant is enrolled in a managed care plan and elects a home birth, the participant must be disenrolled from the managed care program and receive all services through the FFS program.

Comment 95
13 CSR 70-55.010 MO HealthNet Program Benefits for Nurse-Midwife Services

There is no logical reason to restrict the choice of Missouri women to have a home birth with a safe provider! Cover planned homebirth. Also cover doula services.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-55.010. The MHD currently reimburses Nurse Midwives for home births through the Fee-for-Service (FFS) program. If applicable to the participant's eligibility, the MHD will reimburse for delivery in the office, birthing center, hospital, and home. If the participant is enrolled in a managed care plan and elects a home birth, the participant must be disenrolled from the managed care program and receive all services through the FFS program.

Comment 96
13 CSR 70-55.010 MO HealthNet Program Benefits for Nurse-Midwife Services

Being pregnant is not a sickness. If a women chooses to give birth outside of a hospital setting with a qualified nurse or midwife, whether in a birth center or for a home birth, she should be allowed to do so without fear. An insurance company should not have the power to dictate where a women can give birth. You would think that the amount of money saved by having a home or birthing center birth verses a hospital would be an appeal to an insurance company because there are fewer fees involved that need coverage. A home birth or birthing center birth for an average healthy adult women is just as safe as a hospital birth when done with a qualified nurse or midwife so why take that option away from us.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-55.010. The MHD currently reimburses Nurse Midwives for home births through the Fee-for-Service (FFS) program. If applicable to the participant's eligibility, the MHD will reimburse for delivery in the office, birthing center, hospital, and home. If the participant is enrolled in a managed care plan and elects a home birth, the participant must be disenrolled from the managed care program and receive all services through the FFS program.

Comment 97
13 CSR 70-60.010 Durable Medical Equipment Program

Prior Rep. in MO; Pharmacy and home medical equipment company; durable medical equipment; Manual price – acquisition plus 20% - he has to send his fees to DSS; Reg says MHD will provide a "fee schedule" but manual pricing is not a "fee." Doesn't like disclosing his invoice; in private sector – no one should have to disclose either – msrp – pay would be fair; has been this way for years; costs aren't covered with the acquisition plus 20%; travel, maintenance, etc. is not covered. He works with Donnell Holiday at MHD – good partners with him. He is the MHD Durable Medical Equipment Advisory Chairman. Every county should have a "welfare office;" in Perry County there is only a "resource center." Caseworkers are no longer in the community with the people.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-60.010. The MHD is submitting amendments to its pharmacy regulation to update and address some of the concerns expressed in the comments.

The MHD will coordinate with program staff and the DME advisory committee to address the provider's concerns.

The FSD is responsible for the resource offices for Missouri Medicaid participants. The MHD will communicate with the FSD regarding the concerns about the resource centers.

Comment 98
13 CSR 70-90.010 Home Health-Care Program

Definition of visit not to exceed certain time. Confused on how this should be applied. How will changes affect new workers/consumers.

Response:

Thank you for your comment regarding the MO HealthNet Division's regulation 13 CSR 70-90.010. The participant's plan of care will specify the required visits and services for each individual participant approved for the type of Home Health Care services as medically necessary. A participant may contact the participant services unit at 1-800-392-2161 to address any concerns related to their eligibility and coverage. A provider may contact the provider communications unit at 573-751-2896 to discuss a participant's eligibility and coverage information.

Comment 99
13 CSR 70-91.010 Personal Care Program

This is in response to the QA/Personnel Advisory Board and Division of Personnel Regulation Review e-mail.

I currently deal with the following regulations, RSMO's and Manuals on a regular basis:

19 CSR 15-7.021, In-Home personal care regulation, Department of Health and Senior Services (DHSS)

19 CSR 14-8.400, Consumer Directed Services (CDS), DHSS

19 CSR 15-9.100, Electronic Visit Verification (EVV), DHSS

19 CSR 30-82.060 Hiring Restrictions-Good Cause Waiver, DHSS

RSMO 192.2495, Family Care Safety Registry (FCSR), DHSS

RSMO 192.2400, Employee Disqualification List, DHSS

13 CSR 70-91.010, Personal Care Program, Mo HealthNet (MHD)

13 CSR 70-3.030, Sanctions for False or Fraudulent Claims for MO HealthNet Services, MHD

Personal Care Manual, MHD

Aged and Disabled Waiver Manual, MHD

Adult Day Care Waiver Manual, MHD

I will try to address a few regulation/program concerns because I'm sure you do not want a book and most of what I have to say has already been said by someone else. Hopefully I can reinforce what you already know. My approach is not that of a public servant who deals with the Home and Community Based Services (HCBS) program every day, but also a tax payer and someone who's interested in participant safety and provider compliance.

Regulations 19 CSR 15-7.021 and 13 CSR 70-91.010 both deal with the In-Home program but disagree on some points. I believe there is some talk about 13 CSR 70-91.010 going away, this would be great. 19 CSR 15-7.021 needs to be updated. Section (4) (A) 4, (18) (C), (19) (G) and (24) (D). Providers should not have to screen aides because each aide should have to enroll and have a number. State could screen the aide when he/she enrolls. This would save the provider time in screening and would ensure the screening is completed. Currently some providers fail to complete the screening or do not complete it timely so we have unscreened aides serving participants. Some of these aides have very serious charges against them. Also when the services are billed MHD, the claim would have the aide's number on it. This would help in the audit process if money needed to be recouped. Also, if needed, the aide could be disenrolled. In the current system it's easy for bad aides to jump from provider to provider. I know some states currently have a system that enrolls the aide. We would need some type of system to enable providers to easily check aide enrollment. Having aides enrolled and screened by the state would not only save providers time, it would make the screening the same for everyone. Currently personal care employees in an RCF/ ALF only apply for Good Cause Waiver (GCW) if they have a finding that's a crime against persons. In-Home aides and CDS attendants have to apply for a GCW for any finding. In the Adult Day Care program, they have to check the EDL every 90

days. Presently the In-Home employees and CDS attendants are only required to be screened at time of employment. So, you could hire on as an aide, pass the screening, and go sell drugs and steal, call in sick on days you have court, and keep right on working.

Section (5) addresses the proposal process. Currently you can go on line, buy the proposal, fill your company name in the correct blanks and submit it to MMAC. Today you're flipping hamburgers and tomorrow you're an In-Home or CDS provider. Most people would think this was a success story. It has not been a success for the Medicaid system or participants. The majority of these providers have not read the regulations and do not know how to run a business. Because of this, we have fraud issues and participant care issues. A person wanting to be a provider needs some type of professional training. Some type of medical and business training would be great. Maybe it should be required they be an RN or have a business degree.

Section (18) (S) and (T) is really outdated.

Section (21) (B) Should be removed. Why should the provider have to report it if only 80% of the services are being delivered?

All aide training needs to be updated because a lot of things have changed in Health Care since this regulation was written. Should have the provider organizations submit improved training plans for the state to review and incorporate the best ideas into the new regulation.

Going back to the Proposal Process for a minute: It should be in the regulation that providers have to have a commercial business office. This would solve a lot of problems. I will mention only one. Handicap accessibility is checked on the pre-site-visit for In-Home and CDS providers that are in the proposal process. Most of the time, a rent- a-ramp is on the front stairs of the provider's home with the storm door propped open. Of course, this ramp comes off as soon as the state employee leaves.

CDS regulation 19 CSR 15-8.400: before I address a few things in this regulation, I believe we should have one way to receive HCBS services. The CDS program is an extremely fraudulent program. I'm told the FEDS (CMS) are "in love" with this program. Someone may need to educate them. The initial idea may be good (having family taking care of family) but it opens the door for fraud. We have seen instances where the attendant and consumer worked to fraud the system. Time sheets were completed and signed but no services were provided. The money was split between the consumer and attendant. In some cases, the provider had the consumer sign the time sheet, and the provider and consumer split the money. The attendant was working another full-time job, and documenting providing service in the same time period. It has been promoted as an employment plan. These are just a few issues. Our Medicaid system would be in better shape if we had one way to receive services and it was the In-Home model with a few changes. Expand transportation and what hours services are provided. Currently most In-Home providers do not provide service after 5 P .M. Some of the younger participants may need service a little later in the day. Having the aide/attendant work for an agency works a lot better than having the attendant work for the

consumer. No relatives should work for relatives and the agency should do the training and have oversite of the employee. If the program has to stay, I want to touch on a few changes. 19 CSR 15-8.400 (4) (A) 1. Would be removed because the state would be completing the screening when the attendant is enrolled. (4) (F) all case management needs to be a monthly, unannounced visit in the consumer's home. CDS Providers need to attend a yearly state training. (7) (G) and (H) I would discontinue quarterly reports and (J) the annual audit. The state can get a little information off of the quarterly reports but we spend more in man hours than the information we receive is worth. The annual audit costs the provider a lot of money, and serves no great purpose to the state. The annual audit is a burden to small providers. In-Home providers are not required to provide quarterly reports or annual audits. Providers that provide In-Home-service are required to give 21-day notice when discontinuing service; this also needs to be added to CDS. Under 19 CSR 15-8.100 Definitions (1) (C) it states "Consumer does not include any individual with a legal limitation of his or her ability to make decisions, including the appointment of a guardian or conservator, or who has an effective power of attorney that authorizes another person to act as the agent or on behalf of the individual for any of the duties required by the CDS program:". But today we have consumers receiving CDS that have a POA, etc. What makes this even worse is that some of the POA's are the care givers signing the timesheets for the participants. In St. Louis, we have an over flow of CDS providers. We have so many providers that the state is promoting fraud. What I mean by "promoting fraud" is we have a limited number of participants and an over flow of CDS providers wanting to attract those participants any way they can. This is not a good environment for small business or consumers. No one would lose service if a state-wide moratorium was put in place. I know the state has talked to CMS about this, but this really needs to happen.

19 CSR 15-9.100, Electronic Visit Verification: I would do away with this regulation and insert the language into the other regulations. This regulation had some of the teeth removed before the ink was dry. The intent was that all providers would document tasks but the CDS providers got by with documenting the five or six categories they documented on paper timesheets. Also for EVV to work correctly, we must stop using the participant's phone. Currently we have a big issue with government phones. On most participant government phones, they have 400 minutes a month. If the provider uses 5 minutes a day on a 30 day month they will use 150 minutes. Participants can refuse to let the aides use their phone. It's time the EVV requirement is moved away from the phone to other technologies.

The final In-Home regulation needs to have language that applies specifically to personal care delivered in an RCF/ ALF. When in a facility around the clock with two or three shifts, it changes the way things are documented. I believe they are mandated to have EVV by 2019 so this should be included in their part of the regulation. Some call this the "double dip program" because the RCF/ALF is being paid by a relative, or taking the person's Social Security check, etc. so personal care services are provided. But the state, through the personal care program, pays

the RCF/ ALF again for these services. This provider type receives roughly eight million dollars a year.

Day Care Regulation: You notice I have no number. This is because MHD has no regulation for this program. The audit agency is told we have the Licensure and Regulation, Adult Day Care Waiver Manual and Aged and Disabled Waiver Manual and we do not need a regulation. But we have no regulation on what we are going to audit. The other problem is that a manual does not hold up when in appeal at the AHC.

We need strong language in every regulation concerning the loss of services for the participant, and loss of being a provider if fraud is committed. Having this as the Sanction regulation is great but it really needs to be enforced by other regulation also. This is not meant to sound hard nosed or uncaring, but we must protect the taxpayer money and I believe at some point most taxpayers would say "no" to fraud.

A few other issues and I will close.

Mental Health-The state pours a lot of money into these programs and the money rolls out without proper oversight. Once again, we have family members getting paid to take care of family members. My heart goes out for anyone that has a disabled child, but something is wrong when these families have a better income off of Medicaid than most taxpayers. Also MMAC enrolls the state's 56,000 Medicaid providers but not Mental Health providers. If my memory serves me right, they have 12 regions across the state but the rules differ between each region.

Reassessments for HCBS services-Paying the providers to complete reassessment is a poor system. I understand DHSS needed a quick solution. We have nothing in regulation regarding this process. This is one place where we need an outside vendor to do these reassessments. I know last time it did not work out, but we need to try again. I'm really concerned that if the LOC goes to 24 points, we will still have the previous 21 LOC participants on services.

Most of the HCBS providers are honest and care for the participants they serve, but we need to give them good guidance and weed out the fraudulent providers.

Of course, any changes in these rules will cause a firestorm. We have providers that bill Medicaid over 20 million dollars a year for the services I discussed above. Many of these providers also provide and bill Medicaid for Home Health, Hospice and Mental Health services. They are not afraid to protect their interests.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-91.010. In reviewing the comments, the MHD continues to work with other departments and across department divisions to ensure participant safety and provider education. The MHD commits to this coordination as an on-going process to continually improve the MHD regulations.

Comment 100

13 CSR 70-91.010 Personal Care Program

13 CSR 70-91.010 (Personal Care Program)

*Please note in all sections where it states “RN” should be replaced with “Licensed Nurse”

*Please note in all sections where it refers to RCF 1 or RCF 2 should be replaced with current RCF/ALF language

(1)(B)3 Strike “which shall be forwarded to the Department of Health and Senior Services or its designee”

(2)(B)1 thru 7 Replace this entire section with language in CSR 70-91.020 (1)(B)1 A thru V so that services are consistent with all providers

(3)(G)2 Strike “the care of the elderly, disabled or infirm” and replace with “others”

(3)(H)2 Strike entire section as language is outdated

(3)(H)3 Strike entire section as language is outdated

(3)(J)1 Strike this section as it will be a cost benefit to the state

(3)(J)3 Strike this section as language is outdated

(3)(K)1-4 Strike this entire section as facilities are already required to follow employment laws

(4)C(II) End section at “by date of service” and strike “and by staff shifts during each 24 hour period”

(4)F Strike this section as language is unclear and over burdensome for facility and recipient

(4)(B)5 Strike this section as it conflicts with state plan

(4) Add new section (C) to state “”A resident of a licensed facility under RSMO 198 who is eligible for personal care services, if prescribed by a physician, be authorized up to one (1) hour of personal care services per day”

(4) Add new section (D) to state “Previously authorized personal care units shall be transferred with recipient if he/she transfers from one provider to another”

(5)(B)1-5 In each section where it states” include/ing “ add “”but not limited to”

(5)(B)6 Strike “directed by a licensed nurse” and end sentence with “ordered”

(5)(D) Strike “RN”

(5)(E)1 Strike “LPN and replace with “licensed nurse”

(5)(E)1 Add after “has received personal care training” add “or employed by a facility licensed through RSMO 198”. Strike last sentence as this is over burdensome

(5)(E)2A Strike “LPN and replace with “licensed nurse”

(5)(E)3 Strike “an RCF II” and replace with “a facility licensed through RSMO 198”

(5)(E)5 Strike “RN” through this section. In addition add after “the aide’s personnel record” add “or is an employee licensed by RSMO 198

(5)(E)6 Strike “RN”

(5)(E)7 Strike “RN” and replace with “licensed nurse”

(5)(F)2A Strike “RN”

(5)(F)3 Strike section as language is unnecessary

(6)(A) Strike language after first sentence as language is over burdensome and unnecessary

(6)(B)2 Strike section as language is unnecessary

(6)(D)7 Strike this section as language is outdated and unnecessary

(6)(F) Strike "written notes and observations" and replace with "hand written or electronic notes". In addition strike the last sentence beginning with "In addition, notes of any….."

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-91.010. The MHD appreciates the comments and suggestions and as a result will evaluate them for applicable changes to improve the MHD regulations.

Comment 101

13 CSR 70-91.010 Personal Care Program

(1)(G) The definition is different from the MHN Aged and Disabled Waiver definition. For consistency purposes, the homemaker definition should be the same in all manuals and rules. In the draft, clean living area is listed however in the ADW manual included tidying & trash, sweeping and/or vacuuming and mopping floors.

(2)(B)5. In this draft Consumer Directed Services is now held to this same standard. This becomes an issue, since the time frame of starting services depends upon when the Consumer hires their attendant and all required background screenings are received. Since in CDS no conditional employment is allowed thus making services a challenge to start within a seven-day time frame. – suggest to distinguish this requirement is for In-Home only.

(2)(C)5. This draft added the 21-day notice to discontinue services to Consumer Directed Services and during this period the CDS vendor must continue to provide care in accordance with the centered care plan for 21 days or until arrangements can be made by the DHSS or its designee. This is contradicted to the previous ability to suspend Consumer after notice to the Consumer and DHSS in certain situations. Page 14- (15) F. does allow suspension of services only for falsification of records or fraud. Suggest to distinguish this requirement for In-Home only.

(3)(A)2.A. Meal preparation was omitted from this sentence – what is intent of omission?

(3)(B)2.F. Recommend adding under F. or add additional category to include Lymphedema wraps and sleeves, ACE wraps and class II dressing, (compression hose/stocking) and inflatable boots for swelling of the extremities can be applied as long as participant can remove them on their own.

(3)(B)2.G. Recommend adding under G. TENS – Transcutaneous Electrical Nerve Stimulation Unit electrodes. Placement of TENS unit electrodes to the participant's as long as the participant can turn the machine on and off. Disconnect and reconnect insulin pump tubing. Steady hand for pin prick blood sugar monitoring/PT INR and read levels.

(3)(B)2.I. Recommend adding under I: Mechanical/ Hoyer, Sit to Stand, slide board, sling, Barton Chair, Trapeze, gait belt and Pivot device.

(3)(C)4.A. Based on previous research submitted to Department, would like this changed to 2-week supply, (if suitable per insulin manufactory guidance). To

maintain additional insulin prepared in the home in case of a situation where the nurse could not go to the home in a one-week time frame.

(3)(C)4.F. suggest adding the word "task" before the word training.

(3)(C)4.G. Based on limited reimbursement and RN staff shortage would like this requirement changed to allow an LPN the ability to perform the APC task training. LPN's have this skillset and the LPN cost to provider outweighs the benefit of requiring an RN to provide this service.

(3)(C)4.I. A monthly visit report is documented through a provider general health evaluation and level of care recommendation form. Suggestion: To allow providers to use their own Nurse Visit form to reduce burdensome process.

(3)(D)1.B. what is intent of this – need more clarification.

(3)(D)1.D. But listed on page 3 (C) 5 …. Vendor shall provide written notice of discharge to the participant or participant's legal representative and DHSS or its designee at least twenty-one days prior to the date of discharge. Does the twenty-one-day notice apply under D.? Then on Page 14- (15) F. does allow suspension of services only for falsification of records or fraud.

(4)(C) In CDS we would train the consumer on universal precautions and procedures, so questioning the wording of this sentence if it belongs here on as part of training for the consumer.

(4)(D) In the CDS program there is no nursing oversight or visits therefore contacting the CDS Consumer's physician should not be a requirement? Suggest to distinguish for In Home only.

(5)(A)3. Decrease timeframe to 3 months and 6 months due to caregiver shortage.

(5)(C) We would like classroom definition to include on-line and eLearning training

(5)(E) Under 5 (B) On the job training is not listed as part of orientation training. Remove the Supervised on the Job Training Review in the PC Manual or add requirement to this rule. Revise the supervisor or experience aide to: who has been employed by a provider agency at least 6 months. PC Manual -The on the job training review shall consist of the observation of the aide's performance of hands-on personal care tasks under the direction of a designated trainer. Trainer(s) may be the RN, LPN, supervisor or an experienced aide who has been employed by the provider agency at least six (6) months. This review may take place during an on-site visit to a participant or in a classroom demonstration and must be performed within 30 days of the first date of employment.

(5)(F)2. Suggest decreasing to 2 years due to low reimbursement and nursing shortage.

(5)(G)7. Change sentence to read: May assist in orientation and personal care training for aides as needed.

(5)(J)1. Eliminate the 3 months, 15 hour per week minimum waiting period before APC aides qualify to take APC training. This is a burdensome record keeping process. APC aides would still receive the 8 hour classroom and OJT task training.

(5)(J)6. Suggest the RN supervisor may delegate the task training to another RN. Ultimately we would like to allow LPNs to perform PC task training under the supervision of the RN.

(5)(J)7. Request to change I, (use of assistive device for transfers) to observed in either a home or lab setting due to the burdensome and adversely effect on the client to be subjected to such training.

(5)(I)1. For the safety and privacy of the client, would like to remove the Medicaid number from the timesheet to protect the participant in case the time sheet is lost or stolen.

(5)(I)5. There is not a requirement for the aide to sign the timesheet listed under this section nor if the signature is required for each day of service. Is this an oversight?

(6)(D)9.B. Is there a reason why the time sheet requirements for CDS and In-home services are not the same? It would be gainful to make the timesheet requirements the same in both programs. (Discrepancy examples: Medicaid #, aide/attendant signature; each date of service verses each visit). Suggest no Medicaid # and to sign at each date of service.

(6)(F)1.A. Previously if services are to be suspended notification to the CDS Consumer must occur. This seems to contradict the 21-day notice added requirement to CDS listed on Page 4.

Is there a reason a vendor may only suspend services when falsification of records or fraud occurs and any other circumstances would require a 21-day notice?

Below is the previous broader list Vendors could, after notice to DHSS:

(A) May suspend services to consumers in the following circumstances:

1. The inability of the consumer to self-direct;
2. Falsification of records or fraud;
3. Persistent actions by the consumer of noncompliance with the plan of care;
4. The consumer or a member of the consumer household threatens or abuses the attendant and/or vendor; and/or
5. The attendant is not providing services as set forth in the plan of care and attempts to remedy the situation have been unsuccessful;

(6)(N)2. suggest add the word agent to this list after vendor.

(7)(B)4. Should this amount be changed to 60%?

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-91.010. In reviewing the comments, the MHD continues to work with other departments and across department divisions to appropriately describe requirements for in-home services. The MHD commits to this coordination as an on-going process to continually improve the MHD regulations.

The MHD appreciates the additional comments and suggestions and as a result will evaluate them for applicable changes to improve the MHD regulations.

Comment 102
13 CSR 70-95.010 Private Duty Nursing
HCBS Regulation for Consideration of Elimination or Reduction

13 CSR 70-95.010 Private Duty Nursing

(1) Service Definition. Private duty nursing is the provision of individual and continuous care (in contrast to part-time or intermittent care) provided according to an individual plan of care approved by a physician, by licensed nurses acting within the scope of the Missouri Nurse Practice Act. Services within the MO Health Net private duty nursing program include:

(A) Shift care by a registered nurse (RN); and

Comment: Allow graduate nurses to be employed pending the outcome of the nurse licensure examination, not to exceed a period of six months in which follows the Nurse Practice Act. (Home Health regulations allow this)

(B) Shift care by a licensed practical nurse (LPN).

Comment: Allow graduate nurse to be employed pending the outcome of the nurse licensure examination, not to exceed a period of six months in which follows the Nurse Practice Act. (Home Health regulations allow this)

(5) Qualification Requirements for Private Duty Nursing Direct Care Staff and Supervisors.

(C) …. Before contact with clients, all employees who will be delivering services in the home must pass a health assessment or physical examination, including tuberculosis (TB) testing, conducted by a physician or a nurse. Self-assessment will not be accepted for LPN and RN staff……. Annual TB testing is required, with documentation to be maintained by the provider.

Comment: In-home Nursing in the PC program does not require annual TB testing. To make requirements compatible with In-home Nursing or require a paper screening, not a PPD skin test. Suggest eliminating the required employee health assessment.

(7) Requirements for Supervision of Private Duty Nursing Staff.

(A) Each agency shall employ an RN, with three (3) years' experience, to act as supervisor to all other nursing staff. One (1) year of experience must either be in supervisory position or in the field of pediatric nursing.

Comment: Due to staffing shortages and low reimbursement rates allow a combination of LPN and RN years to meet the three years of experience.

(B) All nursing staff providing direct care shall have an annual performance evaluation completed by an RN supervisor, maintained in the personnel record. The evaluation must be based on a minimum of two (2) on-site visits with the staff person present.

Comment: The RN is already in the home every 60 days doing plan of care, assessing the child, family members, etc. Therefore, we suggest a decrease to 1 on-site visit annually.

Section 12.2A of the Private Duty Nursing Manual -- Combined or partial units are not billable to MHN.

Comment: Agencies using the mandated EVV in other HCBS programs should not be penalized for using in their Private Duty Nursing side. We suggest allowing accrual of minutes in consistency with other HCBS programs.

Plan of Care (485's) – When PDN and HCY- Personal Care are both authorized a combined Plan of Care (485) is acceptable even though they have separate NPIs if both NPIs and services are documented. Clarification is needed.

Nurse Practitioner Signing Plan of Care – clarification needed on NP signing POC and only listing physician name. This is in conflict with Medicare rules.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-95.010. The MHD is currently discussing allowing graduate nurses to provide services to MHD participants pending their licensure.

The MHD is currently reviewing the TB test requirements for considerable changes to the MHD regulation.

The MHD appreciates the comments regarding the requirements for nursing staff and will consider analyzing for further consideration.

The MHD is currently working with Centers for Medicare and Medicaid Services (CMS) in adhering to the Electronic Visit Verification (EVV) requirements.

In reviewing the comments, the MHD continues to work with other departments and across department divisions to ensure clarification of requirements crossing departmental regulations. The MHD commits to this coordination as an on-going process to continually improve the MHD regulations.

Comment 103

13 CSR 70-98.015 Behavioral Health Services Program Documentation

Delete 70-98.015 3.A.3 – remove the section that limits MHD billable hours to 150 and recommend that billable hours are based on diagnosis, treatment and outcomes.

Question how section 70-98.020 (5) is impacted by mental health parity, again limiting sessions, rather than an individual outcome based approach to treatment.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-98.015. The MHD has completed a parity analysis and is working to amend this regulation.

Comment 104

13 CSR 70-98.015 Behavioral Health Services Program Documentation

The large number of very specific documentation requirements are an administrative burden preventing some providers from being willing to accept Medicaid participants or other insureds. These substantial documentation requirements are not expected of other medical providers and create a barrier to behavioral health providers devoting time to real patient needs because of the enormous time spent on paperwork.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-98.015. The MHD has completed a parity analysis and is working to amend this regulation.

Comment 105
13 CSR 70-98.020 Prior Authorization Process for Non-Pharmaceutical Behavioral Health Services

This rule is a possible violation of the federal Mental Health Parity and Addiction Equity Act, which generally prevents treatment limitations from being imposed on behavioral health benefits when they are not present for med/surg benefits. The PA requirements for behavioral health services clearly place a burden on behavioral health providers that providers of E and M services do not have. Medical doctors do not complete PAs when they see patients for more than 4 visits to adjust their depression medication, but a psychologist must complete a PA after 4 sessions of psychotherapy. This makes no sense as patient's treated with medication are likely to continue taking that medication long term, whereas, those treated in psychotherapy are likely to eventually have no further need for treatment (saving state resources). Further, in reality, the initial PA process is a formality as they are automatically granted for covered diagnoses. The state of MO is having to pay someone to process PAs that are always going to be granted. Eliminating this burden would again, save the state resources and reduce the already substantial paperwork burden on behavioral health providers.

Response:

Thank you for your comments regarding the MO HealthNet Division's regulation 13 CSR 70-98.020 Prior Authorization Process for Non-Pharmaceutical Behavioral Health Services. The MHD has completed a parity analysis and is working to amend this regulation.

Comment 106
13 CSR 110-2.150 Division of Youth Services Staff Training Programs

Section (2) says The division will also be responsible for extending training opportunities to other public and private youth serving agencies. Couldn't that also work the other way around? DYS should also take advantage of training opportunities that other public and private agencies provide to their employees and members. Why not collaborate with the Children's Division, Corrections, Mental Health, and private organizations in the community to meet specific training needs? It would also help staff get to know these other entities better, network, and provide wraparound services where necessary. DYS trainers could look into this.

Response:

Thank you for your comments regarding the Division of Youth Service's regulation 13 CSR 110-2.150. This regulation speaks to the division establishing comprehensive training programs for all staff and offering those trainings to other public and private entities engaged with preventing delinquency and those providing programs for the treatment of delinquent youth. The comment about collaborating with other agencies to provide additional training opportunities will be shared with our training coordinator. The Division of Youth Services does seek out opportunities to partner with our sister agencies as well as other entities

offering training that will add value to our programs, staff and youth. We have in the past collaborated with private and public entities to offer additional training needs and will continue to be open to those opportunities in the future.