

House _____ Amendment NO. _____

Offered By

1 AMEND Senate Substitute for Senate Bill No. 414, Page 1, Section A, Line 2, by inserting after
2 said section and line the following:

3
4 "208.146. 1. The program established under this section shall be known as the "Ticket to
5 Work Health Assurance Program". Subject to appropriations and in accordance with the federal
6 Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), Public Law 106-170,
7 the medical assistance provided for in section 208.151 may be paid for a person who is employed
8 and who:

9 (1) Except for earnings, meets the definition of disabled under the Supplemental Security
10 Income Program or meets the definition of an employed individual with a medically improved
11 disability under TWWIIA;

12 (2) Has earned income, as defined in subsection 2 of this section;

13 (3) Meets the asset limits in subsection 3 of this section;

14 (4) Has net income, as defined in subsection 3 of this section, that does not exceed the limit
15 for permanent and totally disabled individuals to receive nonspenddown MO HealthNet under
16 subdivision (24) of subsection 1 of section 208.151; and

17 (5) Has a gross income of two hundred fifty percent or less of the federal poverty level,
18 excluding any earned income of the worker with a disability between two hundred fifty and three
19 hundred percent of the federal poverty level. For purposes of this subdivision, "gross income"
20 includes all income of the person and the person's spouse that would be considered in determining
21 MO HealthNet eligibility for permanent and totally disabled individuals under subdivision (24) of
22 subsection 1 of section 208.151. Individuals with gross incomes in excess of one hundred percent of
23 the federal poverty level shall pay a premium for participation in accordance with subsection 4 of
24 this section.

25 2. For income to be considered earned income for purposes of this section, the department
26 of social services shall document that Medicare and Social Security taxes are withheld from such
27 income. Self-employed persons shall provide proof of payment of Medicare and Social Security
28 taxes for income to be considered earned.

29 3. (1) For purposes of determining eligibility under this section, the available asset limit
30 and the definition of available assets shall be the same as those used to determine MO HealthNet
31 eligibility for permanent and totally disabled individuals under subdivision (24) of subsection 1 of
32 section 208.151 except for:

33 (a) Medical savings accounts limited to deposits of earned income and earnings on such
34 income while a participant in the program created under this section with a value not to exceed five
35 thousand dollars per year; and

36 (b) Independent living accounts limited to deposits of earned income and earnings on such

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1 income while a participant in the program created under this section with a value not to exceed five
 2 thousand dollars per year. For purposes of this section, an "independent living account" means an
 3 account established and maintained to provide savings for transportation, housing, home
 4 modification, and personal care services and assistive devices associated with such person's
 5 disability.

6 (2) To determine net income, the following shall be disregarded:

7 (a) All earned income of the disabled worker;

8 (b) The first sixty-five dollars and one-half of the remaining earned income of a nondisabled
 9 spouse's earned income;

10 (c) A twenty dollar standard deduction;

11 (d) Health insurance premiums;

12 (e) A seventy-five dollar a month standard deduction for the disabled worker's dental and
 13 optical insurance when the total dental and optical insurance premiums are less than seventy-five
 14 dollars;

15 (f) All Supplemental Security Income payments, and the first fifty dollars of SSDI
 16 payments;

17 (g) A standard deduction for impairment-related employment expenses equal to one-half of
 18 the disabled worker's earned income.

19 4. Any person whose gross income exceeds one hundred percent of the federal poverty level
 20 shall pay a premium for participation in the medical assistance provided in this section. Such
 21 premium shall be:

22 (1) For a person whose gross income is more than one hundred percent but less than one
 23 hundred fifty percent of the federal poverty level, four percent of income at one hundred percent of
 24 the federal poverty level;

25 (2) For a person whose gross income equals or exceeds one hundred fifty percent but is less
 26 than two hundred percent of the federal poverty level, four percent of income at one hundred fifty
 27 percent of the federal poverty level;

28 (3) For a person whose gross income equals or exceeds two hundred percent but less than
 29 two hundred fifty percent of the federal poverty level, five percent of income at two hundred percent
 30 of the federal poverty level;

31 (4) For a person whose gross income equals or exceeds two hundred fifty percent up to and
 32 including three hundred percent of the federal poverty level, six percent of income at two hundred
 33 fifty percent of the federal poverty level.

34 5. Recipients of services through this program shall report any change in income or
 35 household size within ten days of the occurrence of such change. An increase in premiums resulting
 36 from a reported change in income or household size shall be effective with the next premium
 37 invoice that is mailed to a person after due process requirements have been met. A decrease in
 38 premiums shall be effective the first day of the month immediately following the month in which the
 39 change is reported.

40 6. If an eligible person's employer offers employer-sponsored health insurance and the
 41 department of social services determines that it is more cost effective, such person shall participate
 42 in the employer-sponsored insurance. The department shall pay such person's portion of the
 43 premiums, co-payments, and any other costs associated with participation in the employer-
 44 sponsored health insurance.

45 7. The provisions of this section shall expire August 28, ~~2019~~ 2025.

46 208.151. 1. Medical assistance on behalf of needy persons shall be known as "MO
 47 HealthNet". For the purpose of paying MO HealthNet benefits and to comply with Title XIX,
 48 Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et
 49 seq.) as amended, the following needy persons shall be eligible to receive MO HealthNet benefits to

1 the extent and in the manner hereinafter provided:

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

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

10 (3) All participants receiving blind pension benefits;

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

16 (5) All persons under the age of twenty-one years who would be eligible for aid to families
17 with dependent children except for the requirements of subdivision (2) of subsection 1 of section
18 208.040, and who are residing in an intermediate care facility, or receiving active treatment as
19 inpatients in psychiatric facilities or programs, as defined in 42 U.S.C. Section 1396d, as amended;

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

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

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

27 (9) All persons who were participants receiving old age assistance benefits, aid to the
28 permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who
29 continue to meet the eligibility requirements, except income, for these assistance categories, but
30 who are no longer receiving such benefits because of the implementation of Title XVI of the federal
31 Social Security Act, as amended;

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

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

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

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

46 (14) Children who have attained six years of age but have not attained nineteen years of age.
47 For children who have attained six years of age but have not attained nineteen years of age, the
48 family support division shall use an income assessment methodology which provides for eligibility
49 when family income is equal to or less than equal to one hundred percent of the federal poverty

1 level established by the Department of Health and Human Services, or its successor agency. As
2 necessary to provide MO HealthNet coverage under this subdivision, the department of social
3 services may revise the state MO HealthNet plan to extend coverage under 42 U.S.C. Section 1396a
4 (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained nineteen years
5 of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. Section 1396d using a more
6 liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42
7 U.S.C. Section 1396a;

8 (15) The family support division shall not establish a resource eligibility standard in
9 assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The MO
10 HealthNet division shall define the amount and scope of benefits which are available to individuals
11 eligible under each of the subdivisions (12), (13), and (14) of this subsection, in accordance with the
12 requirements of federal law and regulations promulgated thereunder;

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

16 (17) A child born to a woman eligible for and receiving MO HealthNet benefits under this
17 section on the date of the child's birth shall be deemed to have applied for MO HealthNet benefits
18 and to have been found eligible for such assistance under such plan on the date of such birth and to
19 remain eligible for such assistance for a period of time determined in accordance with applicable
20 federal and state law and regulations so long as the child is a member of the woman's household and
21 either the woman remains eligible for such assistance or for children born on or after January 1,
22 1991, the woman would remain eligible for such assistance if she were still pregnant. Upon
23 notification of such child's birth, the family support division shall assign a MO HealthNet eligibility
24 identification number to the child so that claims may be submitted and paid under such child's
25 identification number;

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

37 (19) Subject to appropriations necessary to recruit and train such staff, the family support
38 division shall provide one or more full-time, permanent eligibility specialists to process applications
39 for MO HealthNet benefits at the site of a health care provider, if the health care provider requests
40 the placement of such eligibility specialists and reimburses the division for the expenses including
41 but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment of such
42 eligibility specialists. The division may provide a health care provider with a part-time or
43 temporary eligibility specialist at the site of a health care provider if the health care provider
44 requests the placement of such an eligibility specialist and reimburses the division for the expenses,
45 including but not limited to the salary, benefits, travel, training, telephone, supplies, and equipment,
46 of such an eligibility specialist. The division may seek to employ such eligibility specialists who are
47 otherwise qualified for such positions and who are current or former welfare participants. The
48 division may consider training such current or former welfare participants as eligibility specialists
49 for this program;

1 (20) Pregnant women who are eligible for, have applied for and have received MO
2 HealthNet benefits under subdivision (2), (10), (11) or (12) of this subsection shall continue to be
3 considered eligible for all pregnancy-related and postpartum MO HealthNet benefits provided under
4 section 208.152 until the end of the sixty-day period beginning on the last day of their pregnancy.
5 Pregnant women receiving substance abuse treatment within sixty days of giving birth shall, subject
6 to appropriations and any necessary federal approval, be eligible for MO HealthNet benefits for
7 substance abuse treatment and mental health services for the treatment of substance abuse for no
8 more than twelve additional months, as long as the woman remains adherent with treatment. The
9 department of mental health and the department of social services shall seek any necessary waivers
10 or state plan amendments from the Centers for Medicare and Medicaid Services and shall develop
11 rules relating to treatment plan adherence. No later than fifteen months after receiving any
12 necessary waiver, the department of mental health and the department of social services shall report
13 to the house of representatives budget committee and the senate appropriations committee on the
14 compliance with federal cost neutrality requirements;

15 (21) Case management services for pregnant women and young children at risk shall be a
16 covered service. To the greatest extent possible, and in compliance with federal law and regulations,
17 the department of health and senior services shall provide case management services to pregnant
18 women by contract or agreement with the department of social services through local health
19 departments organized under the provisions of chapter 192 or chapter 205 or a city health
20 department operated under a city charter or a combined city-county health department or other
21 department of health and senior services designees. To the greatest extent possible the department of
22 social services and the department of health and senior services shall mutually coordinate all
23 services for pregnant women and children with the crippled children's program, the prevention of
24 intellectual disability and developmental disability program and the prenatal care program
25 administered by the department of health and senior services. The department of social services
26 shall by regulation establish the methodology for reimbursement for case management services
27 provided by the department of health and senior services. For purposes of this section, the term
28 "case management" shall mean those activities of local public health personnel to identify
29 prospective MO HealthNet-eligible high-risk mothers and enroll them in the state's MO HealthNet
30 program, refer them to local physicians or local health departments who provide prenatal care under
31 physician protocol and who participate in the MO HealthNet program for prenatal care and to ensure
32 that said high-risk mothers receive support from all private and public programs for which they are
33 eligible and shall not include involvement in any MO HealthNet prepaid, case-managed programs;

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

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

42 (24) (a) All persons who would be determined to be eligible for old age assistance benefits
43 under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section
44 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of
45 January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as
46 authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized
47 by annual appropriation;

48 (b) All persons who would be determined to be eligible for aid to the blind benefits under
49 the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f),

1 or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005,
 2 except that less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2),
 3 shall be used to raise the income limit to one hundred percent of the federal poverty level;

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

11 (25) Persons who have been diagnosed with breast or cervical cancer and who are eligible
 12 for coverage pursuant to 42 U.S.C. Section 1396a(a)(10)(A)(ii)(XVIII). Such persons shall be
 13 eligible during a period of presumptive eligibility in accordance with 42 U.S.C. Section 1396r-1;

14 (26) ~~[Effective August 28, 2013,]~~ Persons who are in foster care under the responsibility of
 15 the state of Missouri on the date such persons attained the age of eighteen years, or at any time
 16 during the thirty-day period preceding their eighteenth birthday, or persons who received foster care
 17 for at least six months in another state, are residing in Missouri, and are at least eighteen years of
 18 age, without regard to income or assets, if such persons:

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

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

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

22 2. Rules and regulations to implement this section shall be promulgated in accordance with
 23 chapter 536. Any rule or portion of a rule, as that term is defined in section 536.010, that is created
 24 under the authority delegated in this section shall become effective only if it complies with and is
 25 subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and
 26 chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to
 27 chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently
 28 held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after
 29 August 28, 2002, shall be invalid and void.

30 3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance
 31 pursuant to 42 U.S.C. Section 601, et seq., as amended, in at least three of the last six months
 32 immediately preceding the month in which such family became ineligible for such assistance
 33 because of increased income from employment shall, while a member of such family is employed,
 34 remain eligible for MO HealthNet benefits for four calendar months following the month in which
 35 such family would otherwise be determined to be ineligible for such assistance because of income
 36 and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. Section
 37 601, et seq., as amended, in at least three of the six months immediately preceding the month in
 38 which such family becomes ineligible for such aid, because of hours of employment or income from
 39 employment of the caretaker relative, shall remain eligible for MO HealthNet benefits for six
 40 calendar months following the month of such ineligibility as long as such family includes a child as
 41 provided in 42 U.S.C. Section 1396r-6. Each family which has received such medical assistance
 42 during the entire six-month period described in this section and which meets reporting requirements
 43 and income tests established by the division and continues to include a child as provided in 42
 44 U.S.C. Section 1396r-6 shall receive MO HealthNet benefits without fee for an additional six
 45 months. The MO HealthNet division may provide by rule and as authorized by annual appropriation
 46 the scope of MO HealthNet coverage to be granted to such families.

47 4. When any individual has been determined to be eligible for MO HealthNet benefits, such
 48 medical assistance will be made available to him or her for care and services furnished in or after
 49 the third month before the month in which he made application for such assistance if such individual

1 was, or upon application would have been, eligible for such assistance at the time such care and
2 services were furnished; provided, further, that such medical expenses remain unpaid.

3 5. The department of social services may apply to the federal Department of Health and
4 Human Services for a MO HealthNet waiver amendment to the Section 1115 demonstration waiver
5 or for any additional MO HealthNet waivers necessary not to exceed one million dollars in
6 additional costs to the state, unless subject to appropriation or directed by statute, but in no event
7 shall such waiver applications or amendments seek to waive the services of a rural health clinic or a
8 federally qualified health center as defined in 42 U.S.C. Section 1396d(l)(1) and (2) or the payment
9 requirements for such clinics and centers as provided in 42 U.S.C. Section 1396a(a)(15) and
10 1396a(bb) unless such waiver application is approved by the oversight committee created in section
11 208.955. A request for such a waiver so submitted shall only become effective by executive order
12 not sooner than ninety days after the final adjournment of the session of the general assembly to
13 which it is submitted, unless it is disapproved within sixty days of its submission to a regular session
14 by a senate or house resolution adopted by a majority vote of the respective elected members
15 thereof, unless the request for such a waiver is made subject to appropriation or directed by statute.

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

21 208.909. 1. Consumers receiving personal care assistance services shall be responsible for:

22 (1) Supervising their personal care attendant;

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

24 (3) Preparing and submitting time sheets, signed by both the consumer and personal care
25 attendant, to the vendor on a biweekly basis;

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

28 (5) Reporting any problems resulting from the quality of services rendered by the personal
29 care attendant to the vendor. If the consumer is unable to resolve any problems resulting from the
30 quality of service rendered by the personal care attendant with the vendor, the consumer shall report
31 the situation to the department; ~~and~~

32 (6) Providing the vendor with all necessary information to complete required paperwork for
33 establishing the employer identification number; and

34 (7) Allowing the vendor to comply with its quality assurance and supervision process,
35 which shall include, but not be limited to, bi-annual face-to-face home visits and monthly case
36 management activities.

37 2. Participating vendors shall be responsible for:

38 (1) Collecting time sheets or reviewing reports of delivered services and certifying the
39 accuracy thereof;

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

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

44 (4) Monitoring the performance of the personal care assistance services plan. Such
45 monitoring shall occur during the bi-annual face-to-face home visits under section 208.918. The
46 vendor shall document whether the attendant was present and if services are being provided to the
47 consumer as set forth in the plan of care. If the attendant was not present or not providing services,
48 the vendor shall notify the department and the department may suspend services to the consumer.

49 3. No state or federal financial assistance shall be authorized or expended to pay for services

1 provided to a consumer under sections 208.900 to 208.927, if the primary benefit of the services is
 2 to the household unit, or is a household task that the members of the consumer's household may
 3 reasonably be expected to share or do for one another when they live in the same household, unless
 4 such service is above and beyond typical activities household members may reasonably provide for
 5 another household member without a disability.

6 4. No state or federal financial assistance shall be authorized or expended to pay for
 7 personal care assistance services provided by a personal care attendant who has not undergone the
 8 background screening process under section 192.2495. If the personal care attendant has a
 9 disqualifying finding under section 192.2495, no state or federal assistance shall be made, unless a
 10 good cause waiver is first obtained from the department in accordance with section 192.2495.

11 5. (1) All vendors shall, by July 1, 2015, have, maintain, and use a telephone tracking
 12 system for the purpose of reporting and verifying the delivery of consumer-directed services as
 13 authorized by the department of health and senior services or its designee. ~~[Use of such a system~~
 14 ~~prior to July 1, 2015, shall be voluntary.]~~ The telephone tracking system shall be used to process
 15 payroll for employees and for submitting claims for reimbursement to the MO HealthNet division.
 16 At a minimum, the telephone tracking system shall:

- 17 (a) Record the exact date services are delivered;
- 18 (b) Record the exact time the services begin and exact time the services end;
- 19 (c) Verify the telephone number from which the services are registered;
- 20 (d) Verify that the number from which the call is placed is a telephone number unique to the
 21 client;
- 22 (e) Require a personal identification number unique to each personal care attendant;
- 23 (f) Be capable of producing reports of services delivered, tasks performed, client identity,
 24 beginning and ending times of service and date of service in summary fashion that constitute
 25 adequate documentation of service; and

26 (g) Be capable of producing reimbursement requests for consumer approval that assures
 27 accuracy and compliance with program expectations for both the consumer and vendor.

28 ~~(2) [The department of health and senior services, in collaboration with other appropriate~~
 29 ~~agencies, including centers for independent living, shall establish telephone tracking system pilot~~
 30 ~~projects, implemented in two regions of the state, with one in an urban area and one in a rural area.~~
 31 ~~Each pilot project shall meet the requirements of this section and section 208.918. The department~~
 32 ~~of health and senior services shall, by December 31, 2013, submit a report to the governor and~~
 33 ~~general assembly detailing the outcomes of these pilot projects. The report shall take into~~
 34 ~~consideration the impact of a telephone tracking system on the quality of the services delivered to~~
 35 ~~the consumer and the principles of self-directed care.~~

36 ~~—(3)]~~ As new technology becomes available, the department may allow use of a more
 37 advanced tracking system, provided that such system is at least as capable of meeting the
 38 requirements of this subsection.

39 ~~[(4)]~~ (3) The department of health and senior services shall promulgate by rule the minimum
 40 necessary criteria of the telephone tracking system. Any rule or portion of a rule, as that term is
 41 defined in section 536.010, that is created under the authority delegated in this section shall become
 42 effective only if it complies with and is subject to all of the provisions of chapter 536 and, if
 43 applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers
 44 vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to
 45 disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking
 46 authority and any rule proposed or adopted after August 28, 2010, shall be invalid and void.

47 ~~[6. In the event that a consensus between centers for independent living and representatives~~
 48 ~~from the executive branch cannot be reached, the telephony report issued to the general assembly~~
 49 ~~and governor shall include a minority report which shall detail those elements of substantial dissent~~

1 from the main report.

2 ~~7. No interested party, including a center for independent living, shall be required to contract~~
 3 ~~with any particular vendor or provider of telephony services nor bear the full cost of the pilot~~
 4 ~~program.]~~

5 208.918. 1. In order to qualify for an agreement with the department, the vendor shall have
 6 a philosophy that promotes the consumer's ability to live independently in the most integrated
 7 setting or the maximum community inclusion of persons with physical disabilities, and shall
 8 demonstrate the ability to provide, directly or through contract, the following services:

9 (1) Orientation of consumers concerning the responsibilities of being an employer~~[,]~~ and
 10 supervision of personal care attendants including the preparation and verification of time sheets.
 11 Such orientation shall include notifying customers that falsification of attendant visit verification
 12 records shall be considered fraud and shall be reported to the department. Such orientation shall
 13 take place in the presence of the personal care attendant, to the fullest extent possible;

14 (2) Training for consumers about the recruitment and training of personal care attendants;

15 (3) Maintenance of a list of persons eligible to be a personal care attendant;

16 (4) Processing of inquiries and problems received from consumers and personal care
 17 attendants;

18 (5) Ensuring the personal care attendants are registered with the family care safety registry
 19 as provided in sections 210.900 to ~~[210.937]~~ 210.936; and

20 (6) The capacity to provide fiscal conduit services through a telephone tracking system by
 21 the date required under section 208.909.

22 2. In order to maintain its agreement with the department, a vendor shall comply with the
 23 provisions of subsection 1 of this section and shall:

24 (1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial
 25 reports and an annual financial statement audit [submitted to the department] performed by a
 26 certified public accountant if the vendor's annual gross revenue is one hundred thousand dollars or
 27 more or, if the vendor's annual gross revenue is less than one hundred thousand dollars, an annual
 28 financial statement audit or annual financial statement review performed by a certified public
 29 accountant. Such reports, audits, and reviews shall be completed and made available upon request
 30 to the department; [and]

31 (2) Demonstrate a positive impact on consumer outcomes regarding the provision of
 32 personal care assistance services as evidenced on accurate quarterly and annual service reports
 33 submitted to the department;

34 (3) Implement a quality assurance and supervision process that ensures program compliance
 35 and accuracy of records;

36 (a) The department of health and senior services shall promulgate by rule a consumer-
 37 directed services division provider certification manager course; and

38 (b) The vendor shall perform with the consumer at least bi-annual face-to-face home visits
 39 to provide ongoing monitoring of the provision of services in the plan of care and assess the quality
 40 of care being delivered. The bi-annual face-to-face home visits do not preclude the vendor's
 41 responsibility from its ongoing diligence of case management activity oversight;

42 (4) Comply with all provisions of sections 208.900 to 208.927, and the regulations
 43 promulgated thereunder; and

44 (5) Maintain a business location which shall comply with any and all applicable city, county,
 45 state, and federal requirements.

46 3. No state or federal funds shall be authorized or expended to pay for personal care
 47 assistance services under sections 208.900 to 208.927 if the person providing the personal care is the
 48 same person conducting the biannual face-to-face home visits or if the owner, primary operator, or
 49 certified manager, or any person employed by, or contracted with, the consumer-directed services

1 vendor serves as the personal care attendant.

2 208.924. A consumer's personal care assistance services may be discontinued under
3 circumstances such as the following:

4 (1) The department learns of circumstances that require closure of a consumer's case,
5 including one or more of the following: death, admission into a long-term care facility, no longer
6 needing service, or inability of the consumer to consumer-direct personal care assistance service;

7 (2) The consumer has falsified records; provided false information of his or her condition,
8 functional capacity, or level of care needs; or committed fraud;

9 (3) The consumer is noncompliant with the plan of care. Noncompliance requires persistent
10 actions by the consumer which negate the services provided in the plan of care;

11 (4) The consumer or member of the consumer's household threatens or abuses the personal
12 care attendant or vendor to the point where their welfare is in jeopardy and corrective action has
13 failed;

14 (5) The maintenance needs of a consumer are unable to continue to be met because the plan
15 of care hours exceed availability; and

16 (6) The personal care attendant is not providing services as set forth in the personal care
17 assistance services plan and attempts to remedy the situation have been unsuccessful.

18 217.930. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than
19 canceled or terminated, for a person who is an offender in a correctional center if:

20 (a) The department of social services is notified of the person's entry into the correctional
21 center;

22 (b) On the date of entry, the person was enrolled in the MO HealthNet program; and

23 (c) The person is eligible for MO HealthNet except for institutional status.

24 (2) A suspension under this subsection shall end on the date the person is no longer an
25 offender in a correctional center.

26 (3) Upon release from incarceration, such person shall continue to be eligible for receipt of
27 MO HealthNet benefits until such time as the person is otherwise determined to no longer be
28 eligible for the program.

29 2. The department of corrections shall notify the department of social services:

30 (1) Within twenty days after receiving information that a person receiving benefits under
31 MO HealthNet is or will be an offender in a correctional center; and

32 (2) Within forty-five days prior to the release of a person who is qualified for suspension
33 under subsection 1 of this section.

34 221.125. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than
35 canceled or terminated, for a person who is an offender in a county jail, a city jail, or a private jail if:

36 (a) The department of social services is notified of the person's entry into the jail;

37 (b) On the date of entry, the person was enrolled in the MO HealthNet program; and

38 (c) The person is eligible for MO HealthNet except for institutional status.

39 (2) A suspension under this subsection shall end on the date the person is no longer an
40 offender in a jail.

41 (3) Upon release from incarceration, such person shall continue to be eligible for receipt of
42 MO HealthNet benefits until such time as the person is otherwise determined to no longer be
43 eligible for the program.

44 2. City, county, and private jails shall notify the department of social services within ten
45 days after receiving information that a person receiving medical assistance under MO HealthNet is
46 or will be an offender in the jail."; and

47
48 Further amend said bill, Page 4, Section 376.1182, Line 35, by inserting after said section and line
49 the following:

1
2 "454.600. As used in sections 454.600 to 454.645, the following terms mean:

3 (1) "Court", any circuit court establishing a support obligation pursuant to an action under
4 this chapter, chapter 210, chapter 211 or chapter 452;

5 (2) "Director", the director of the family support division of the department of social
6 services;

7 (3) "Division", the family support division of the department of social services;

8 (4) "Employer", any individual, organization, agency, business or corporation hiring an
9 obligor for pay;

10 (5) "Health benefit plan", any benefit plan or combination of plans~~[, other than public~~
11 ~~assistance programs,]~~ providing medical or dental care or benefits through insurance or otherwise,
12 including but not limited to health service corporations, as defined in section 354.010; prepaid
13 dental plans, as defined in section 354.700; health maintenance organization plans, as defined in
14 section 354.400; and self-insurance plans, to the extent allowed by federal law;

15 (6) "Minor child", a child for whom a support obligation exists under law;

16 (7) "Obligee", a person to whom a duty of support is owed or a person, including any
17 division of the department of social services, who has commenced a proceeding for enforcement of
18 an alleged duty of support or for registration of a support order, regardless of whether the person to
19 whom a duty of support is owed is a recipient of public assistance;

20 (8) "Obligor", a person owing a duty of support or against whom a proceeding for the
21 enforcement of a duty of support or registration of a support order is commenced;

22 (9) "IV-D case", a case in which support rights have been assigned to the state of Missouri
23 pursuant to section 208.040, or in which the family support division is providing support
24 enforcement services pursuant to section 454.425.

25 454.603. 1. At any state of a proceeding in which the circuit court or the division has
26 jurisdiction to establish or modify an order for child support, including but not limited to actions
27 brought pursuant to this chapter, chapters 210, 211, and 452, the court or the division shall
28 determine whether to require a parent to provide medical care for the child through a health benefit
29 plan.

30 2. ~~[With or without the agreement of the parents,]~~ The court or the division may require that
31 a child be covered under a health benefit plan that is accessible to the child. Such a requirement
32 shall be imposed in any IV-D case. The court or division shall require that a child be covered under
33 a private health benefit plan whenever such a health benefit plan is available at reasonable cost
34 through a parent's employer or union [or in any IV-D case]. If ~~[such]~~ a private health benefit plan is
35 not available at reasonable cost through an employer or union ~~[and the case is not a IV-D case]~~, the
36 court in determining whether to require a parent to provide such coverage, shall consider:

37 (1) The best interests of the child;

38 (2) The child's present and anticipated needs for medical care;

39 (3) The financial ability of the parents to afford the cost of a health benefit plan; and

40 (4) The extent to which the cost of the health benefit plan is subsidized or reduced by
41 participation on a group basis or otherwise.

42 3. To the extent that such options are available under the terms of the health benefit plan, an
43 order may specify required terms of the health benefit plan, including:

44 (1) Minimum required policy limits;

45 (2) Minimum required coverage;

46 (3) Maximum terms for deductibles or required co-payments; or

47 (4) Other significant terms, including, but not limited to, any provision required for a health
48 benefit plan under the federal Employee Retirement Income Security Act of 1974, as amended.

49 4. If the child is not covered by a private health benefit plan but such a plan is available to

1 one of the parents at a reasonable cost, the court or the division shall order that coverage under the
2 health benefit plan be provided for the child unless there is available to the other parent a private
3 health benefit plan with comparable or better benefits at comparable or reduced cost. If private
4 health benefit plans are available to both parents upon terms which provide comparable benefits and
5 costs, the court or the division shall determine which health benefit plan, if any, shall be required,
6 giving due regard to the possible advantages of each plan.

7 5. The court shall require the obligor to be liable for all or a portion of the medical or dental
8 expenses of the minor child that are not covered by the required health benefit plan coverage if:

9 (1) The court finds that the health benefit plan coverage required to be obtained by the
10 obligor or available to the obligee does not pay all the reasonable and necessary medical or dental
11 expenses of the minor child; and

12 (2) The court finds that the obligor has the financial resources to contribute to the payment
13 of these medical or dental expenses; and

14 (3) The court finds the obligee has substantially complied with the terms of the health
15 benefit coverage.

16 6. The cost of health benefit plan employee contributions or premiums shall not be a direct
17 offset to child support awards established pursuant to this chapter, chapters 210, 211, and 452, but it
18 shall be considered when determining the amount of child support to be paid by the obligor.

19 7. If two or more health benefit plans are available to one or both parents that are
20 complementary to one another or are compatible as primary and secondary coverage for the child,
21 the court or the division may order each parent to maintain one or more health benefit plans for the
22 child.

23 8. Prior to terminating enrollment in a health benefit plan or changing from one health
24 benefit plan to another, consideration by the court or division shall be given to the child's medical
25 condition and best interests and whether there is reason to believe that a new health benefit plan
26 would omit or limit benefits because of a preexisting condition.

27 9. An abatement of a parent's child support obligation shall not automatically abate that
28 parent's duty to provide for the child's health care needs. Unless an order of the court or the division
29 specifically provides for abatement or termination of health care coverage, an order to maintain
30 health benefits or otherwise provide for a child's health care needs shall continue in force until
31 further order of the court or the division, or until the child's right to parental support terminates.";
32 and

33
34 Further amend said bill by amending the title, enacting clause, and intersectional references
35 accordingly.