

House _____ Amendment NO. _____

Offered By _____

1 AMEND Senate Bill No. 208, Page1 , In the Title, Line 3, by deleting the words "reentry into the
2 custody of the children's division" and inserting in lieu thereof the words "public welfare"; and
3

4 Further amend said bill, Page 1, Section A, Line 2, by inserting after all of said section and line the
5 following:

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

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

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

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

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

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

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

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

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

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(b) Independent living accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed five thousand dollars per year. For purposes of this section, an "independent living account" means an account established and maintained to provide savings for transportation, housing, home modification, and personal care services and assistive devices associated with such person's disability.

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

(a) All earned income of the disabled worker;

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

(c) A twenty dollar standard deduction;

(d) Health insurance premiums;

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

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

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

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

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

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

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

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

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

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

7. The provisions of this section shall expire [six years after] August 28, [2007] 2019.

208.151. 1. Medical assistance on behalf of needy persons shall be known as "MO HealthNet". For the purpose of paying MO HealthNet benefits and to comply with Title XIX, Public

1 Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.) as
2 amended, the following needy persons shall be eligible to receive MO HealthNet benefits to the
3 extent and in the manner hereinafter provided:

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

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

11 (3) All participants receiving blind pension benefits;

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

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

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

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

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

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

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

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

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

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

47 (14) Children who have attained six years of age but have not attained nineteen years of age.
48 For children who have attained six years of age but have not attained nineteen years of age, the

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

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

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

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

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

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

1 consider training such current or former welfare participants as eligibility specialists for this
2 program;

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

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

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

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

34 (24) (a) All persons who would be determined to be eligible for old age assistance benefits
35 under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section
36 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of January
37 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in
38 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual
39 appropriation;

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

45 (c) All persons who would be determined to be eligible for permanent and total disability
46 benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C.
47 1396a(f); or less restrictive methodologies as contained in the MO HealthNet state plan as of January
48 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in

42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriations. Eligibility standards for permanent and total disability benefits shall not be limited by age;

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

(26) Effective August 28, 2013, persons who are [independent foster care adolescents, as defined in 42 U.S.C. Section 1396d, or who are within reasonable categories of such adolescents who are under twenty-one years of age as specified by the state, are eligible for coverage under 42 U.S.C. Section 1396a (a)(10)(A)(ii)(XVII) without regard to income or assets] in foster care under the responsibility of the state of Missouri on the date such persons attain the age of eighteen years, or at any time during the thirty-day period preceding their eighteenth birthday, without regard to income or assets, if such persons:

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

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

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

2. Rules and regulations to implement this section shall be promulgated in accordance with [section 431.064 and] chapter 536. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.

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

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

5. The department of social services may apply to the federal Department of Health and Human Services for a MO HealthNet waiver amendment to the Section 1115 demonstration waiver

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

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

208.895. 1. Upon the receipt of a properly completed referral for service for MO HealthNet-funded home- and community-based care [containing a nurse assessment] or a physician's order, the department of health and senior services [may] shall:

(1) [Review the recommendations regarding services and] Process, review and approve or deny the referral within fifteen business days;

(2) [Issue a prior-authorization for home and community-based services when information contained in the referral is sufficient to establish eligibility for MO HealthNet-funded long-term care and determine the level of service need as required under state and federal regulations;

(3) Arrange] For approved referrals, arrange for the provision of services by [an in-home] a home- and community-based provider;

[(4) Reimburse the in-home provider for one nurse visit to conduct an assessment and recommendation for a care plan and, where necessary based on case circumstances, a second nurse visit may be authorized to gather additional information or documentation necessary to constitute a completed referral;

(5) Notify the referring entity upon the authorization of MO HealthNet eligibility and provide MO HealthNet reimbursement for personal care benefits effective the date of the assessment or physician's order, and MO HealthNet reimbursement for waiver services effective the date the state reviews and approves the care plan;

(6) (3) Notify the referring entity or individual within five business days of receiving the referral if [additional information] a different physical address is required to [process the referral; and

(7) Inform the provider and contact the individual when information is insufficient or the proposed care plan requires additional evaluation by state staff that is not obtained from the referring entity to schedule an in-home assessment to be conducted by the state staff within thirty days] schedule the assessment. The referring entity has five days to provide a current physical address if requested by the department. If a different physical address is needed, the fifteen-day limit included in subdivision (1) of this subsection is suspended until the information is received by the department;

(4) Inform the applicant of:

(a) The full range of available MO HealthNet home- and community-based services, including, but not limited to, adult day care services, home-delivered meals, and the benefits of self-direction and agency model services;

(b) The choice of home- and community-based service providers in the applicant's area, and that some providers conduct their own assessments, but that choosing a provider who does not

1 conduct assessments will not delay delivery of services; and

2 (c) The option to choose more than one home- and community-based service provider to
 3 deliver or facilitate the services the applicant is qualified to receive;

4 (5) Prioritize the referrals received, giving the highest priority to referrals for high-risk
 5 individuals, followed by individuals who are alleged to be victims of abuse or neglect as a result of
 6 an investigation initiated from the elder abuse and neglect hotline, and then followed by individuals
 7 who have not selected a provider or who have selected a provider that does not conduct assessments;
 8 and

9 (6) Notify the referring entity and the applicant within ten business days of receiving the
 10 referral if it has not scheduled the assessment.

11 2. If the department of health and senior services [may contract for initial home- and
 12 community-based assessments, including a care plan, through an independent third-party assessor.
 13 The contract shall include a requirement that:

14 (1) Within fifteen days of receipt of a referral for service, the contractor shall have made a
 15 face-to-face assessment of care need and developed a plan of care; and

16 (2) The contractor notify the referring entity within five days of receipt of referral if
 17 additional information is needed to process the referral.

18 The contract shall also include the same requirements for such assessments as of January 1, 2010,
 19 related to timeliness of assessments and the beginning of service. The contract shall be bid under
 20 chapter 34 and shall not be a risk-based contract] has not complied with subdivision (1) of subsection
 21 1 of this section, a provider has the option of completing an assessment and care plan
 22 recommendation. At such time that the department approves or modifies the assessment and care
 23 plan, the care plan shall become effective; such approval or modification shall occur within five
 24 business days after receipt of the assessment and care plan from the provider. If such approval,
 25 modification, or denial by the department does not occur within five business days, the provider's
 26 care plan shall be approved and payment shall begin to the provider based on the assessment and care
 27 plan recommendation submitted by the provider.

28 3. [The two nurse visits authorized by subsection 16 of section 660.300 shall continue to be
 29 performed by home- and community-based providers for including, but not limited to, reassessment
 30 and level of care recommendations. These reassessments and care plan changes shall be reviewed
 31 and approved by the independent third-party assessor. In the event of dispute over the level of care
 32 required, the third-party assessor shall conduct a face-to-face review with the client in question.

33 4. The provisions of this section shall expire August 28, 2013] At such time that the
 34 department approves or modifies the assessment and care plan, the latest approved care plan shall
 35 become effective. If the department assessment determines the client does not meet level of care, the
 36 state shall not be responsible for the cost of services claimed prior to the department's written
 37 notification to the provider of such denial.

38 4. The department shall implement subsections 2 and 3 of this section unless the Centers for
 39 Medicare and Medicaid Services disapproves any necessary state plan amendments or waivers to
 40 implement the provisions in subsections 2 and 3 of this section allowing providers to perform
 41 assessments.

42 5. The department's auditing of home- and community-based service providers shall include
 43 a review of the client plan of care and provider assessments, and choice and communication of
 44 home- and community-based service provider service options to individuals seeking MO HealthNet
 45 services. Such auditing shall be conducted utilizing a statistically valid sample. The department
 46 shall also make publicly available a review of its process for informing participants of service
 47 options within MO HealthNet home- and community-based service provider services and
 48 information on referrals.

6. For purposes of this section:

(1) "Assessment" means a face-to-face determination that a MO HealthNet participant is eligible for home- and community-based services and:

(a) Is conducted by an assessor trained to perform home- and community-based care assessments;

(b) Uses forms provided by the department;

(c) Includes unbiased descriptions of each available service within home- and community-based services with a clear person-centered explanation of the benefits of each home- and community-based service, whether the applicant qualifies for more than one service and ability to choose more than one provider to deliver or facilitate services; and

(d) Informs the applicant, either by the department or the provider conducting the assessment, that choosing a provider or multiple providers that do not conduct their own assessments will in no way affect the quality of service or the timeliness of the applicant's assessment and authorization process.

(2) A "properly completed referral" shall contain basic information adequate for the department to contact the client or person needing service. At a minimum, the referral shall contain:

(a) The stated need for MO HealthNet home- and community-based services;

(b) The name, date of birth, and Social Security number of the client or person needing service, or the client's or person's MO HealthNet number; and

(c) The current physical address and phone number of the client or person needing services.

Addition information which may assist the department including contact information of a responsible party shall also be submitted.

7. The department shall:

(1) Develop an automated electronic assessment care plan tool to be used by providers; and

(2) Make recommendations to the general assembly by January 1, 2014, for the implementation of the automated electronic assessment care plan tool.

8. No later than December 31, 2014, the department of health and senior services shall submit a report to the general assembly that reviews the following:

(1) How well the department is doing on meeting the fifteen-day requirement;

(2) The process the department used to approve the assessors;

(3) Financial data on the cost of the program prior to and after enactment of this section;

(4) Any audit information available on assessments performed outside the department; and

(5) The department's staffing policies implemented to meet the fifteen-day assessment requirement.

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

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

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

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

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

2. Notwithstanding any other provisions of law to the contrary, effective January 1, 2014, the

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

4 3. The department, or family support division, shall conduct electronic searches to
 5 redetermine eligibility on the basis of income, residency, citizenship, identity and other criteria as
 6 described in 42 CFR 435.916 upon availability of federal, state, and commercially available
 7 electronic data sources. The department, or family support division, may enter into a contract with a
 8 vendor to perform the electronic search of eligibility information not disclosed during the application
 9 process and obtain an applicable case management system. The department shall retain final
 10 authority over eligibility determinations made during the redetermination process.

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

17 5. Notwithstanding any other provisions of law to the contrary, to be eligible for MO
 18 HealthNet coverage under section 208.995, individuals shall meet the eligibility requirements set
 19 forth in subsection 1 of this section and all other eligibility criteria set forth in 42 CFR 435 and 457,
 20 including, but not limited to, the requirements that:

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

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

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

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

31 (5) An individual claiming eligibility as an uninsured woman shall be uninsured.
 32 208.995. 1. For purposes of this section and section 208.990, the following terms mean:

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

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

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

39 (4) "MAGI", the individual's modified adjusted gross income as defined in Section
 40 36B(d)(2) of the Internal Revenue Code of 1986, as amended, and;

41 (a) Any foreign earned income or housing costs;

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

43 (c) Tax-exempt Social Security income;

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

47 2. (1) Effective January 1, 2014, notwithstanding any other provision of law to the contrary,
 48 the following individuals shall be eligible for MO HealthNet coverage as provided in this section:

- 1 (a) Individuals covered by MO HealthNet for families as provided in section 208.145;
 2 (b) Individuals covered by transitional MO HealthNet as provided in 42 U.S.C. Section
 3 1396r-6;
 4 (c) Individuals covered by extended MO HealthNet for families on child support closings as
 5 provided in 42 U.S.C. Section 1396r-6;
 6 (d) Pregnant women as provided in subdivisions (10), (11), and (12) of subsection 1 of
 7 section 208.151;
 8 (e) Children under one year of age as provided in subdivision (12) of subsection 1 of section
 9 208.151;
 10 (f) Children under six years of age as provided in subdivision (13) of subsection 1 of section
 11 208.151;
 12 (g) Children under nineteen years of age as provided in subdivision (14) of subsection 1 of
 13 section 208.151;
 14 (h) CHIP-eligible children; and
 15 (i) Uninsured women as provided in section 208.659.
 16 (2) Effective January 1, 2014, the department shall determine eligibility for individuals
 17 eligible for MO HealthNet under subdivision (1) of this subsection based on the following income
 18 eligibility standards, unless and until they are changed:
 19 (a) For individuals listed in paragraphs (a), (b) and (c) of subdivision (1) of this subsection,
 20 the department shall apply the July 16, 1996, Aid to Families with Dependent Children (AFDC)
 21 income standard as converted to the MAGI equivalent net income standard;
 22 (b) For individuals listed in paragraphs (f) and (g) of subdivision (1) of this subsection, the
 23 department shall apply one hundred thirty-three percent of the federal poverty level converted to the
 24 MAGI equivalent net income standard;
 25 (c) For individuals listed in paragraph (h) of subdivision (1) of this subsection, the
 26 department shall convert the income eligibility standard set forth in section 208.633 to the MAGI
 27 equivalent net income standard;
 28 (d) For individuals listed in paragraphs (d), (e) and (i) of subdivision (1) of this subsection,
 29 the department shall apply one hundred eighty-five percent of the federal poverty level converted to
 30 the MAGI equivalent net income standard;
 31 (3) Individuals eligible for MO HealthNet under subdivision (1) of this subsection shall
 32 receive all applicable benefits under section 208.152.
 33 3. The department or appropriate divisions of the department shall promulgate rules to
 34 implement the provisions of this section. Any rule or portion of a rule, as the term is defined in
 35 section 536.010, that is created under the authority delegated in this section shall become effective
 36 only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable,
 37 section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with
 38 the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove
 39 and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and
 40 any rule proposed or adopted after August 28, 2013, shall be invalid and void.
 41 4. The department shall submit such state plan amendments and waivers to the Centers for
 42 Medicare and Medicaid Services of the federal Department of Health and Human Services as the
 43 department determines are necessary to implement the provisions of this section."; and
 44

45 Further amend said bill and page, Section 211.036, Line 7, by inserting after all of said section and
 46 line the following:

47 "660.315. 1. After an investigation and a determination has been made to place a person's
 48 name on the employee disqualification list, that person shall be notified in writing mailed to his or

her last known address that:

(1) An allegation has been made against the person, the substance of the allegation and that an investigation has been conducted which tends to substantiate the allegation;

(2) The person's name will be included in the employee disqualification list of the department;

(3) The consequences of being so listed including the length of time to be listed; and

(4) The person's rights and the procedure to challenge the allegation.

2. If no reply has been received within thirty days of mailing the notice, the department may include the name of such person on its list. The length of time the person's name shall appear on the employee disqualification list shall be determined by the director or the director's designee, based upon the criteria contained in subsection 9 of this section.

3. If the person so notified wishes to challenge the allegation, such person may file an application for a hearing with the department. The department shall grant the application within thirty days after receipt by the department and set the matter for hearing, or the department shall notify the applicant that, after review, the allegation has been held to be unfounded and the applicant's name will not be listed.

4. If a person's name is included on the employee disqualification list without the department providing notice as required under subsection 1 of this section, such person may file a request with the department for removal of the name or for a hearing. Within thirty days after receipt of the request, the department shall either remove the name from the list or grant a hearing and set a date therefor.

5. Any hearing shall be conducted in the county of the person's residence by the director of the department or the director's designee. The provisions of chapter 536 for a contested case except those provisions or amendments which are in conflict with this section shall apply to and govern the proceedings contained in this section and the rights and duties of the parties involved. The person appealing such an action shall be entitled to present evidence, pursuant to the provisions of chapter 536, relevant to the allegations.

6. Upon the record made at the hearing, the director of the department or the director's designee shall determine all questions presented and shall determine whether the person shall be listed on the employee disqualification list. The director of the department or the director's designee shall clearly state the reasons for his or her decision and shall include a statement of findings of fact and conclusions of law pertinent to the questions in issue.

7. A person aggrieved by the decision following the hearing shall be informed of his or her right to seek judicial review as provided under chapter 536. If the person fails to appeal the director's findings, those findings shall constitute a final determination that the person shall be placed on the employee disqualification list.

8. A decision by the director shall be inadmissible in any civil action brought against a facility or the in-home services provider agency and arising out of the facts and circumstances which brought about the employment disqualification proceeding, unless the civil action is brought against the facility or the in-home services provider agency by the department of health and senior services or one of its divisions.

9. The length of time the person's name shall appear on the employee disqualification list shall be determined by the director of the department of health and senior services or the director's designee, based upon the following:

(1) Whether the person acted recklessly or knowingly, as defined in chapter 562;

(2) The degree of the physical, sexual, or emotional injury or harm; or the degree of the imminent danger to the health, safety or welfare of a resident or in-home services client;

(3) The degree of misappropriation of the property or funds, or falsification of any

documents for service delivery of an in-home services client;

(4) Whether the person has previously been listed on the employee disqualification list;

(5) Any mitigating circumstances;

(6) Any aggravating circumstances; and

(7) Whether alternative sanctions resulting in conditions of continued employment are appropriate in lieu of placing a person's name on the employee disqualification list. Such conditions of employment may include, but are not limited to, additional training and employee counseling. Conditional employment shall terminate upon the expiration of the designated length of time and the person's submitting documentation which fulfills the department of health and senior services' requirements.

10. The removal of any person's name from the list under this section shall not prevent the director from keeping records of all acts finally determined to have occurred under this section.

11. The department shall provide the list maintained pursuant to this section to other state departments upon request and to any person, corporation, organization, or association who:

(1) Is licensed as an operator under chapter 198;

(2) Provides in-home services under contract with the department;

(3) Employs nurses and nursing assistants for temporary or intermittent placement in health care facilities;

(4) Is approved by the department to issue certificates for nursing assistants training;

(5) Is an entity licensed under chapter 197;

(6) Is a recognized school of nursing, medicine, or other health profession for the purpose of determining whether students scheduled to participate in clinical rotations with entities described in subdivision (1), (2), or (5) of this subsection are included in the employee disqualification list; or

(7) Is a consumer reporting agency regulated by the federal Fair Credit Reporting Act that conducts employee background checks on behalf of entities listed in subdivisions (1), (2), (5), or (6) of this subsection. Such a consumer reporting agency shall conduct the employee disqualification list check only upon the initiative or request of an entity described in subdivisions (1), (2), (5), or (6) of this subsection when the entity is fulfilling its duties required under this section. The information shall be disclosed only to the requesting entity.

The department shall inform any person listed above who inquires of the department whether or not a particular name is on the list. The department may require that the request be made in writing. No person, corporation, organization, or association who is entitled to access the employee disqualification list may disclose the information to any person, corporation, organization, or association who is not entitled to access the list. Any person, corporation, organization, or association who is entitled to access the employee disqualification list who discloses the information to any person, corporation, organization, or association who is not entitled to access the list shall be guilty of an infraction.

12. No person, corporation, organization, or association who received the employee disqualification list under subdivisions (1) to (7) of subsection 11 of this section shall knowingly employ any person who is on the employee disqualification list. Any person, corporation, organization, or association who received the employee disqualification list under subdivisions (1) to (7) of subsection 11 of this section, or any person responsible for providing health care service, who declines to employ or terminates a person whose name is listed in this section shall be immune from suit by that person or anyone else acting for or in behalf of that person for the failure to employ or for the termination of the person whose name is listed on the employee disqualification list.

13. Any employer [who is] or vendor as defined in sections 197.250, 197.400, 198.006, 208.900, or 660.250 required to [discharge an employee because the employee was placed on a disqualification list maintained by the department of health and senior services after the date of hire]

1 deny employment to an applicant or to discharge an employee, provisional or otherwise, as a result
2 of information obtained through any portion of the background screening and employment eligibility
3 determination process under section 210.903, or subsequent, periodic screenings, shall not be liable
4 in any action brought by the applicant or employee relating to discharge where the employer is
5 required by law to terminate the employee, provisional or otherwise, and shall not be charged for
6 unemployment insurance benefits based on wages paid to the employee for work prior to the date of
7 discharge, pursuant to section 288.100[.], if the employer terminated the employee because the
8 employee:

9 (1) Has been found guilty, pled guilty or nolo contendere in this state or any other state of a
10 crime as listed in subsection 6 of section 660.317;

11 (2) Was placed on the employee disqualification list under this section after the date of hire;

12 (3) Was placed on the employee disqualification registry maintained by the department of
13 mental health after the date of hire;

14 (4) Has a disqualifying finding under this section, section 660.317, or is on any of the
15 background check lists in the family care safety registry under sections 210.900 to 210.936; or

16 (5) Was denied a good cause waiver as provided for in subsection 10 of section 660.317.

17 14. Any person who has been listed on the employee disqualification list may request that
18 the director remove his or her name from the employee disqualification list. The request shall be
19 written and may not be made more than once every twelve months. The request will be granted by
20 the director upon a clear showing, by written submission only, that the person will not commit
21 additional acts of abuse, neglect, misappropriation of the property or funds, or the falsification of any
22 documents of service delivery to an in-home services client. The director may make conditional the
23 removal of a person's name from the list on any terms that the director deems appropriate, and failure
24 to comply with such terms may result in the person's name being relisted. The director's
25 determination of whether to remove the person's name from the list is not subject to appeal."; and

26
27 Further amend said bill by amending the title, enacting clause, and intersectional references
28 accordingly.
29
30
31