CCS HCS SB 127 -- PUBLIC ASSISTANCE BENEFITS

This bill changes the laws regarding public assistance benefits.

The bill extends the provisions regarding the Ticket to Work Health Assurance Program from August 28, 2013, to August 28, 2019, and specifies that a person who is in foster care on the date he or she turns 18 years of age or in the 30 days before turning 18 is eligible for MO HealthNet benefits without regard to income or assets if the person is younger than 26 years of age, is not eligible for coverage under another mandatory coverage group, and was covered by the MO HealthNet Program while he or she was in foster care.

Drugs and medicines that are prescribed by an advanced practice registered nurse and the services of an advanced practice registered nurse with a collaborative practice agreement are added to the list of services that must be paid for by the MO HealthNet Program.

The MO HealthNet Division within the Department of Social Services may implement a statewide dental delivery system to ensure recipient participation and access to dental services under MO HealthNet to providers in all areas of the state. The division may seek a third party experienced in the administration of dental benefits to administer the program under the division's supervision.

The bill changes the laws regarding MO HealthNet-funded home- and community-based care. The Department of Health and Senior Services is required, upon receiving a properly completed referral for service or a physician's order for service for MO HealthNet funded home- and community-based care, to:

(a) Process, review, and approve or deny the referral within 15 business days of its receipt;

(b) Arrange for the provision of services by a home- and community-based provider for approved referrals;

(c) Notify the referring entity or individual within five business days of receiving the referral if a different physical address is required to schedule the assessment. The referring entity must provide a current physical address within five days if requested by the department. If a different physical address is needed, the 15-day deadline is suspended until the department receives the requested information;

(d) Inform the applicant of the full range of available MO

HealthNet home- and community-based services, including adult day care services, home-delivered meals, and the benefits of self-direction and agency model services; the choice of service providers in the applicant's area; and the option to choose more than one service provider to deliver or facilitate the services the applicant is qualified to receive;

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

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

The bill repeals the provisions allowing the Department of Health and Senior Services to contract for an initial home- and community-based assessment, including a care plan, through an independent third-party assessor and allows a provider to complete an assessment and care plan recommendation if the department fails to process, review, and approve or deny a referral within 15 business days. The department must approve or modify the assessment and care plan submitted by the provider within five business days of its receipt for the plan to become effective. If the department fails to approve, modify, or deny the provider's plan within five business days, the plan must be approved and payment must begin. The latest approved care plan must become effective when the department approves or modifies an assessment and care plan. If the department assessment determines that the client does not meet the level of care in the provider's plan, the state must not be responsible for the cost of services claimed prior to the department's written notification to the provider of the denial. The department must implement these provisions unless the Centers for Medicare and Medicaid Services disapproves any necessary state plan amendments or waivers to implement the provisions allowing providers to perform assessments.

The department's audit of a home- and community-based service provider must include a review of the client plan of care, provider assessments, and choice and communication of service options to the individuals seeking MO HealthNet services. The audit must be conducted utilizing a statistically valid sample, and the department must make publicly available a review of its process for informing participants of service options within MO HealthNet home- and community-based service provider services and information on referrals.

The bill requires the department to develop an automated electronic assessment care plan tool to be used by providers and by January 1, 2014, to make recommendations to the General Assembly for the implementation of the automated electronic assessment care plan tool.

The department must submit a report by December 31, 2014, to the General Assembly that reviews:

(a) How well the department is meeting the 15-day requirement;

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

(c) The financial data on the cost of the program prior to and after enactment;

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

(e) The department's staffing policies implemented to meet the 15-day assessment requirement.

In order to be eligible for MO HealthNet benefits, an individual must be a resident of Missouri; have a valid Social Security number; be a citizen of the United States or a qualified alien with satisfactory documentary evidence of qualified alien status that has been verified by the federal Department of Homeland Security; and if claiming eligibility as a pregnant woman, she must verify the pregnancy. Beginning January 1, 2014, the Family Support Division within the Department of Social Services must conduct an annual redetermination of all MO HealthNet participants' eligibility. The department may contract with an administrative service organization to conduct the annual redetermination if it is cost effective. The department or division must conduct electronic searches to redetermine eligibility on the basis of income, residency, citizenship, identity, and other criteria upon availability of electronic data sources. The department or division may enter into a contract with a vendor to perform the electronic searches of eligibility information not disclosed during the application process and obtain an applicable case management system. The department will retain final authority over eligibility determinations made during the redetermination process.

An individual who is applying for MO HealthNet benefits must submit an application in accordance with applicable federal law, including 42 CFR 435.907, and provide all required information and documentation necessary to make an eligibility determination, resolve discrepancies found during the redetermination process, or

for any purpose directly connected to the administration of the medical assistance program.

The department must determine an individual's financial eligibility based on projected annual household income and family size for the remainder of the current year and determine the modified adjusted gross household income by including all available cash support provided by the person claiming the individual as a dependent for tax purposes. A pregnant woman's household size is to be determined by counting the pregnant woman plus the number of children she is expected to deliver. A CHIP-eligible child must be uninsured and not have access to affordable insurance, and the child's parent must pay the required premium. An individual claiming eligibility as an uninsured woman must be uninsured. The income eligibility standards are specified in the bill.

An employer or vendor as defined in Sections 197.250, 197.400, 198.006, 208.900, or 660.250, RSMo, who is required to deny employment to an applicant or to discharge an employee as a result of information obtained through any portion of the background screening and employment eligibility determination process or subsequent, periodic screenings cannot be liable in any action brought by the applicant or employee relating to discharge if the employer is required by law to terminate the employee and cannot be charged for unemployment insurance benefits based on wages paid to the employee for work prior to the date of discharge if the employer terminated the employee because the employee:

(a) Has been found guilty or pled guilty or nolo contendere of specified crimes;

(b) Was placed on the employee disqualification list maintained by the Department of Health and Senior Services after the date of hire;

(c) Was placed on the employee disqualification registry maintained by the Department of Mental Health after the date of hire;

(d) Has a disqualifying finding or is on any background check list in the Family Care Safety Registry of the Department of Health and Senior Services; or

(e) Was denied a good cause waiver under Section 660.317.