

HOUSE SUBSTITUTE AMENDMENT NO. \_\_\_\_\_

for

HOUSE \_\_\_\_\_ AMENDMENT NO. \_\_\_\_\_

Offered By

AMEND House Committee Substitute for Senate Bill No. 275, Page 22, Section 196.100, Line 18,  
by inserting after said section and line the following:

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

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

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

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

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

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

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

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

(a) Medical savings 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; and

(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

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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 August 28, ~~[2019]~~ 2025.

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

- (1) All participants receiving state supplemental payments for the aged, blind and disabled;
- (2) All participants receiving aid to families with dependent children benefits, including all persons under nineteen years of age who would be classified as dependent children except for the requirements of subdivision (1) of subsection 1 of section 208.040. Participants eligible under this subdivision who are participating in treatment court, as defined in section 478.001, shall have their eligibility automatically extended sixty days from the time their dependent child is removed from the custody of the participant, subject to approval of the Centers for Medicare and Medicaid Services;
- (3) All participants receiving blind pension benefits;
- (4) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits under the eligibility standards in effect December 31,

1 1973, or less restrictive standards as established by rule of the family support division, who are sixty-five  
2 years of age or over and are patients in state institutions for mental diseases or tuberculosis;

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

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

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

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

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

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

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

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

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

31 (14) Children who have attained six years of age but have not attained nineteen years of age. For  
32 children who have attained six years of age but have not attained nineteen years of age, the family support  
33 division shall use an income assessment methodology which provides for eligibility when family income is  
34 equal to or less than equal to one hundred percent of the federal poverty level established by the Department  
35 of Health and Human Services, or its successor agency. As necessary to provide MO HealthNet coverage  
36 under this subdivision, the department of social services may revise the state MO HealthNet plan to extend  
37 coverage under 42 U.S.C. Section 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but  
38 have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. Section  
39 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r)  
40 of 42 U.S.C. Section 1396a;

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

46 (16) Notwithstanding any other provisions of law to the contrary, ambulatory prenatal care shall be  
47 made available to pregnant women during a period of presumptive eligibility pursuant to 42 U.S.C. Section  
48 1396r-1, as amended;

49 (17) A child born to a woman eligible for and receiving MO HealthNet benefits under this section on  
50 the date of the child's birth shall be deemed to have applied for MO HealthNet benefits and to have been  
51 found eligible for such assistance under such plan on the date of such birth and to remain eligible for such  
52 assistance for a period of time determined in accordance with applicable federal and state law and regulations  
53 so long as the child is a member of the woman's household and either the woman remains eligible for such

1 assistance or for children born on or after January 1, 1991, the woman would remain eligible for such  
 2 assistance if she were still pregnant. Upon notification of such child's birth, the family support division shall  
 3 assign a MO HealthNet eligibility identification number to the child so that claims may be submitted and paid  
 4 under such child's identification number;

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

15 (19) Subject to appropriations necessary to recruit and train such staff, the family support division  
 16 shall provide one or more full-time, permanent eligibility specialists to process applications for MO  
 17 HealthNet benefits at the site of a health care provider, if the health care provider requests the placement of  
 18 such eligibility specialists and reimburses the division for the expenses including but not limited to salaries,  
 19 benefits, travel, training, telephone, supplies, and equipment of such eligibility specialists. The division may  
 20 provide a health care provider with a part-time or temporary eligibility specialist at the site of a health care  
 21 provider if the health care provider requests the placement of such an eligibility specialist and reimburses the  
 22 division for the expenses, including but not limited to the salary, benefits, travel, training, telephone, supplies,  
 23 and equipment, of such an eligibility specialist. The division may seek to employ such eligibility specialists  
 24 who are otherwise qualified for such positions and who are current or former welfare participants. The  
 25 division may consider training such current or former welfare participants as eligibility specialists for this  
 26 program;

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

40 (21) Case management services for pregnant women and young children at risk shall be a covered  
 41 service. To the greatest extent possible, and in compliance with federal law and regulations, the department  
 42 of health and senior services shall provide case management services to pregnant women by contract or  
 43 agreement with the department of social services through local health departments organized under the  
 44 provisions of chapter 192 or chapter 205 or a city health department operated under a city charter or a  
 45 combined city-county health department or other department of health and senior services designees. To the  
 46 greatest extent possible the department of social services and the department of health and senior services  
 47 shall mutually coordinate all services for pregnant women and children with the crippled children's program,  
 48 the prevention of intellectual disability and developmental disability program and the prenatal care program  
 49 administered by the department of health and senior services. The department of social services shall by  
 50 regulation establish the methodology for reimbursement for case management services provided by the  
 51 department of health and senior services. For purposes of this section, the term "case management" shall  
 52 mean those activities of local public health personnel to identify prospective MO HealthNet-eligible high-risk  
 53 mothers and enroll them in the state's MO HealthNet program, refer them to local physicians or local health

1 departments who provide prenatal care under physician protocol and who participate in the MO HealthNet  
 2 program for prenatal care and to ensure that said high-risk mothers receive support from all private and public  
 3 programs for which they are eligible and shall not include involvement in any MO HealthNet prepaid, case-  
 4 managed programs;

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

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

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

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

22 (c) All persons who would be determined to be eligible for permanent and total disability benefits  
 23 under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f); or  
 24 less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005; except that,  
 25 on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section  
 26 1396a(r)(2), may be used to change the income limit if authorized by annual appropriations. Eligibility  
 27 standards for permanent and total disability benefits shall not be limited by age;

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

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

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

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

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

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

46 3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to  
 47 42 U.S.C. Section 601, et seq., as amended, in at least three of the last six months immediately preceding the  
 48 month in which such family became ineligible for such assistance because of increased income from  
 49 employment shall, while a member of such family is employed, remain eligible for MO HealthNet benefits  
 50 for four calendar months following the month in which such family would otherwise be determined to be  
 51 ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family  
 52 receiving aid pursuant to 42 U.S.C. Section 601, et seq., as amended, in at least three of the six months  
 53 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. Section 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. Section 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. Section 1396d(l)(1) and (2) or the payment requirements for such clinics and centers as provided in 42 U.S.C. Section 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).

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

- (1) Supervising their personal care attendant;
- (2) Verifying wages to be paid to the personal care attendant;
- (3) Preparing and submitting time sheets, signed by both the consumer and personal care attendant, to the vendor on a biweekly basis;
- (4) Promptly notifying the department within ten days of any changes in circumstances affecting the personal care assistance services plan or in the consumer's place of residence;
- (5) Reporting any problems resulting from the quality of services rendered by the personal care attendant to the vendor. If the consumer is unable to resolve any problems resulting from the quality of service rendered by the personal care attendant with the vendor, the consumer shall report the situation to the department; ~~and~~

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

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

2. Participating vendors shall be responsible for:

- (1) Collecting time sheets or reviewing reports of delivered services and certifying the accuracy thereof;
- (2) The Medicaid reimbursement process, including the filing of claims and reporting data to the department as required by rule;
- (3) Transmitting the individual payment directly to the personal care attendant on behalf of the consumer;
- (4) Monitoring the performance of the personal care assistance services plan. Such monitoring shall occur during the bi-annual face-to-face home visits under section 208.918. The vendor shall document

whether the attendant was present and if services are being provided to the consumer as set forth in the plan of care. If the attendant was not present or not providing services, the vendor shall notify the department and the department may suspend services to the consumer.

3. No state or federal financial assistance shall be authorized or expended to pay for services provided to a consumer under sections 208.900 to 208.927, if the primary benefit of the services is to the household unit, or is a household task that the members of the consumer's household may reasonably be expected to share or do for one another when they live in the same household, unless such service is above and beyond typical activities household members may reasonably provide for another household member without a disability.

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

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

- (a) Record the exact date services are delivered;
- (b) Record the exact time the services begin and exact time the services end;
- (c) Verify the telephone number from which the services are registered;
- (d) Verify that the number from which the call is placed is a telephone number unique to the client;
- (e) Require a personal identification number unique to each personal care attendant;
- (f) Be capable of producing reports of services delivered, tasks performed, client identity, beginning and ending times of service and date of service in summary fashion that constitute adequate documentation of service; and
- (g) Be capable of producing reimbursement requests for consumer approval that assures accuracy and compliance with program expectations for both the consumer and vendor.

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

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

~~[(4)]~~ (3) The department of health and senior services shall promulgate by rule the minimum necessary criteria of the telephone tracking system. 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, 2010, shall be invalid and void.

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

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

208.918. 1. In order to qualify for an agreement with the department, the vendor shall have a

philosophy that promotes the consumer's ability to live independently in the most integrated setting or the maximum community inclusion of persons with physical disabilities, and shall demonstrate the ability to provide, directly or through contract, the following services:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

208.930. 1. As used in this section, the term "department" shall mean the department of health and senior services.

2. Subject to appropriations, the department may provide financial assistance for consumer-directed personal care assistance services through eligible vendors, as provided in sections 208.900 through 208.927, to each person who was participating as a non-MO HealthNet eligible client pursuant to sections 178.661 through 178.673 on June 30, 2005, and who:

(1) Makes application to the department;

(2) Demonstrates financial need and eligibility under subsection 3 of this section;

(3) Meets all the criteria set forth in sections 208.900 through 208.927, except for subdivision (5) of subsection 1 of section 208.903;

(4) Has been found by the department of social services not to be eligible to participate under guidelines established by the MO HealthNet plan; and

(5) Does not have access to affordable employer-sponsored health care insurance or other affordable health care coverage for personal care assistance services as defined in section 208.900. For purposes of this section, "access to affordable employer-sponsored health care insurance or other affordable health care coverage" refers to health insurance requiring a monthly premium less than or equal to one hundred thirty-three percent of the monthly average premium required in the state's current Missouri consolidated health care plan.

Payments made by the department under the provisions of this section shall be made only after all other available sources of payment have been exhausted.

3. (1) In order to be eligible for financial assistance for consumer-directed personal care assistance services under this section, a person shall demonstrate financial need, which shall be based on the adjusted gross income and the assets of the person seeking financial assistance and such person's spouse.

(2) In order to demonstrate financial need, a person seeking financial assistance under this section and such person's spouse must have an adjusted gross income, less disability-related medical expenses, as approved by the department, that is equal to or less than three hundred percent of the federal poverty level. The adjusted gross income shall be based on the most recent income tax return.

(3) No person seeking financial assistance for personal care services under this section and such person's spouse shall have assets in excess of two hundred fifty thousand dollars.

4. The department shall require applicants and the applicant's spouse, and consumers and the consumer's spouse, to provide documentation for income, assets, and disability-related medical expenses for the purpose of determining financial need and eligibility for the program. In addition to the most recent income tax return, such documentation may include, but shall not be limited to:

(1) Current wage stubs for the applicant or consumer and the applicant's or consumer's spouse;

(2) A current W-2 form for the applicant or consumer and the applicant's or consumer's spouse;

(3) Statements from the applicant's or consumer's and the applicant's or consumer's spouse's employers;

(4) Wage matches with the division of employment security;

(5) Bank statements; and

(6) Evidence of disability-related medical expenses and proof of payment.

5. A personal care assistance services plan shall be developed by the department pursuant to section 208.906 for each person who is determined to be eligible and in financial need under the provisions of this section. The plan developed by the department shall include the maximum amount of financial assistance allowed by the department, subject to appropriation, for such services.

6. Each consumer who participates in the program is responsible for a monthly premium equal to the average premium required for the Missouri consolidated health care plan; provided that the total premium described in this section shall not exceed five percent of the consumer's and the consumer's spouse's adjusted gross income for the year involved.

1           7. (1) Nonpayment of the premium required in subsection 6 shall result in the denial or termination  
2 of assistance, unless the person demonstrates good cause for such nonpayment.

3           (2) No person denied services for nonpayment of a premium shall receive services unless such  
4 person shows good cause for nonpayment and makes payments for past-due premiums as well as current  
5 premiums.

6           (3) Any person who is denied services for nonpayment of a premium and who does not make any  
7 payments for past-due premiums for sixty consecutive days shall have their enrollment in the program  
8 terminated.

9           (4) No person whose enrollment in the program is terminated for nonpayment of a premium when  
10 such nonpayment exceeds sixty consecutive days shall be reenrolled unless such person pays any past-due  
11 premiums as well as current premiums prior to being reenrolled. Nonpayment shall include payment with a  
12 returned, refused, or dishonored instrument.

13           8. (1) Consumers determined eligible for personal care assistance services under the provisions of  
14 this section shall be reevaluated annually to verify their continued eligibility and financial need. The amount  
15 of financial assistance for consumer-directed personal care assistance services received by the consumer shall  
16 be adjusted or eliminated based on the outcome of the reevaluation. Any adjustments made shall be recorded  
17 in the consumer's personal care assistance services plan.

18           (2) In performing the annual reevaluation of financial need, the department shall annually send a  
19 reverification eligibility form letter to the consumer requiring the consumer to respond within ten days of  
20 receiving the letter and to provide income and disability-related medical expense verification documentation.  
21 If the department does not receive the consumer's response and documentation within the ten-day period, the  
22 department shall send a letter notifying the consumer that he or she has ten days to file an appeal or the case  
23 will be closed.

24           (3) The department shall require the consumer and the consumer's spouse to provide documentation  
25 for income and disability-related medical expense verification for purposes of the eligibility review. Such  
26 documentation may include but shall not be limited to the documentation listed in subsection 4 of this  
27 section.

28           9. (1) Applicants for personal care assistance services and consumers receiving such services  
29 pursuant to this section are entitled to a hearing with the department of social services if eligibility for  
30 personal care assistance services is denied, if the type or amount of services is set at a level less than the  
31 consumer believes is necessary, if disputes arise after preparation of the personal care assistance plan  
32 concerning the provision of such services, or if services are discontinued as provided in section 208.924.  
33 Services provided under the provisions of this section shall continue during the appeal process.

34           (2) A request for such hearing shall be made to the department of social services in writing in the  
35 form prescribed by the department of social services within ninety days after the mailing or delivery of the  
36 written decision of the department of health and senior services. The procedures for such requests and for the  
37 hearings shall be as set forth in section 208.080.

38           10. Unless otherwise provided in this section, all other provisions of sections 208.900 through  
39 208.927 shall apply to individuals who are eligible for financial assistance for personal care assistance  
40 services under this section.

41           11. The department may promulgate rules and regulations, including emergency rules, to implement  
42 the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is  
43 created under the authority delegated in this section shall become effective only if it complies with and is  
44 subject to all of the provisions of chapter 536 and, if applicable, section 536.028. Any provisions of the  
45 existing rules regarding the personal care assistance program promulgated by the department of elementary  
46 and secondary education in title 5, code of state regulations, division 90, chapter 7, which are inconsistent  
47 with the provisions of this section are void and of no force and effect.

48           ~~[12. The provisions of this section shall expire on June 30, 2019.]~~

49           217.930. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than canceled or  
50 terminated, for a person who is an offender in a correctional center if:

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

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

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

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

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

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

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

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

Further amend said bill, Page 23, Section 221.111, Line 34, by inserting after said section and line the following:

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

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

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

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

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

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

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

Further amend said bill, Page 55, Section 376.1578, Line 24, by inserting after said section and line the following:

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

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

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

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

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

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

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

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

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

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

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

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

12 (1) The best interests of the child;  
 13 (2) The child's present and anticipated needs for medical care;  
 14 (3) The financial ability of the parents to afford the cost of a health benefit plan; and  
 15 (4) The extent to which the cost of the health benefit plan is subsidized or reduced by participation  
 16 on a group basis or otherwise.

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

19 (1) Minimum required policy limits;  
 20 (2) Minimum required coverage;  
 21 (3) Maximum terms for deductibles or required co-payments; or  
 22 (4) Other significant terms, including, but not limited to, any provision required for a health benefit  
 23 plan under the federal Employee Retirement Income Security Act of 1974, as amended.

24 4. If the child is not covered by a private health benefit plan but such a plan is available to one of the  
 25 parents at a reasonable cost, the court or the division shall order that coverage under the health benefit plan be  
 26 provided for the child unless there is available to the other parent a private health benefit plan with  
 27 comparable or better benefits at comparable or reduced cost. If private health benefit plans are available to  
 28 both parents upon terms which provide comparable benefits and costs, the court or the division shall  
 29 determine which health benefit plan, if any, shall be required, giving due regard to the possible advantages of  
 30 each plan.

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

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

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

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

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

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

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

50 9. An abatement of a parent's child support obligation shall not automatically abate that parent's duty  
 51 to provide for the child's health care needs. Unless an order of the court or the division specifically provides  
 52 for abatement or termination of health care coverage, an order to maintain health benefits or otherwise  
 53 provide for a child's health care needs shall continue in force until further order of the court or the division, or

1 until the child's right to parental support terminates."; and

2

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

4

5 THIS SUBSTITUTES 1192H05.41H