House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND House Committee Substitute for Senate Bill No. 514, Page 1, Section A, Line 3, by inserting after said section and line the following:

"191.737. 1. Notwithstanding the physician-patient privilege, any physician or health care provider may refer to the children's division families in which children may have been exposed to a controlled substance listed in section 195.017, schedules I, II and III, or alcohol as evidenced by a written assessment, made or approved by a physician, health care provider, or by the children's division, that documents the child as being at risk of abuse or neglect and either:

(1) Medical documentation of signs and symptoms consistent with controlled substances or alcohol exposure in the child at birth; or

(2) Results of a confirmed toxicology test for controlled substances performed at birth on the mother or the child[~~; and~~

~~(3) A written assessment made or approved by a physician, health care provider, or by the children's division which documents the child as being at risk of abuse or neglect~~].

2. Notwithstanding the physician-patient privilege, any physician or health care provider shall refer to the children's division families in which infants are born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder as evidenced by:

(1) Medical documentation of signs and symptoms consistent with controlled substances or alcohol exposure in the child at birth; or

(2) Results of a confirmed toxicology test for controlled substances performed at birth on the mother or the child.

[~~2~~]3. Nothing in this section shall preclude a physician or other mandated reporter from reporting abuse or neglect of a child as required pursuant to the provisions of section 210.115.

[~~3~~]4. Any physician or health care provider complying with the provisions of this section, in good faith, shall have immunity from any civil liability that might otherwise result by reason of such actions.

[4]5. Referral and associated documentation provided for in this section shall be confidential and shall not be used in any criminal prosecution.

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

Action Taken_____ Date _____

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 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."; and

Further amend said bill, Page 7, Section 208.151, Line 228, by inserting after said section and line the following:

"208.896. 1. To ensure the availability of comprehensive and cost-effective choices for MO HealthNet participants who have been diagnosed with Alzheimer's or related disorders as defined in section 172.800, to live at home in the community of their choice and to receive support from the caregivers of their choice, the department of social services shall apply to the United States Secretary of Health and Human Services for a structured family caregiver waiver under Section 1915(c) of the federal Social Security Act. Federal approval of the waiver is necessary to implement the provisions of this section. Structured family caregiving shall be considered an agency-directed model, and no financial management services shall be required.

2. The structured family caregiver waiver shall include:

(1) A choice for participants of qualified and credentialed caregivers, including family caregivers;

(2) A choice for participants of community settings in which they receive structured family caregiving. A caregiver may provide structured family caregiving services in the caregiver's home or the participant's home, but the caregiver shall reside full time in the same home as the participant;

(3) A requirement that caregivers under this section are added to the family care safety registry and comply with the provisions of sections 210.900 to 210.936;

(4) A requirement that all caregivers shall obtain liability insurance as required;

(5) A cap of three hundred participants to receive structured family caregiving;

(6) A requirement that all organizations serving as structured family caregiving agencies are considered in-home service provider agencies and are accountable for documentation of services delivered, meeting the requirements set forth for these provider agencies, qualification and requalification of caregivers and homes, caregiver training, providing a case manager or registered nurse to create a service plan tailored to each participant's needs, professional staff support for

eligible people, ongoing monitoring and support through monthly home visits, deployment of electronic daily notes, and remote consultation with families;

(7) Caregivers are accountable for providing for the participant's personal care needs. This includes, but is not limited to, laundry, housekeeping, shopping, transportation, and assistance with activities of daily living;

(8) A daily payment rate for services that is adequate to pay stipends to caregivers and pay provider agencies for the cost of providing professional staff support as required under this section and administrative functions required of in-home services provider agencies. The payment to the provider agency is not to exceed thirty-five percent of the daily reimbursement rate; and

(9) Daily payment rates for structured family caregiving services that do not exceed sixty percent of the daily nursing home cost cap established by the state each year.

3. (1) Within ninety days of the effective date of this section, the department of social services shall, if necessary to implement the provisions of this section, apply to the United States Secretary of Health and Human Services for a structured family caregiver waiver. The department of social services shall request an effective date before July 2, 2020, and shall, by such date, take all administrative actions necessary to ensure timely and equitable availability of structured family caregiving services for home- and community-based care participants.

(2) Upon receipt of an approved waiver under subdivision (1) of this subsection, the department of health and senior services shall promulgate rules to implement the provisions of this section. 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, 2019, shall be invalid and void.

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.

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

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

(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 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."

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 11, Section 338.720, Line 42, 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.

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

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

(1) The best interests of the child;

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

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

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

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

(1) Minimum required policy limits;

(2) Minimum required coverage;

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

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

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

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

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

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

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

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

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

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

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

and

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