

FIRST REGULAR SESSION
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 466
100TH GENERAL ASSEMBLY

Reported from the Committee on Seniors, Families and Children, April 30, 2019, with recommendation that the Senate Committee Substitute do pass.

1272S.03C

ADRIANE D. CROUSE, Secretary.

AN ACT

To repeal sections 208.146, 208.151, 208.225, 208.790, 208.909, 208.918, and 208.924, RSMo, and to enact in lieu thereof ten new sections relating to medical public assistance.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Sections 208.146, 208.151, 208.225, 208.790, 208.909, 208.918, 2 and 208.924, RSMo, are repealed and ten new sections enacted in lieu thereof, to 3 be known as sections 208.146, 208.151, 208.225, 208.790, 208.896, 208.909, 4 208.918, 208.924, 217.930, and 221.125, to read as follows:

208.146. 1. The program established under this section shall be known 2 as the "Ticket to Work Health Assurance Program". Subject to appropriations 3 and in accordance with the federal Ticket to Work and Work Incentives 4 Improvement Act of 1999 (TWWIIA), Public Law 106-170, the medical assistance 5 provided for in section 208.151 may be paid for a person who is employed and 6 who:

- 7 (1) Except for earnings, meets the definition of disabled under the 8 Supplemental Security Income Program or meets the definition of an employed 9 individual with a medically improved disability under TWWIIA;
- 10 (2) Has earned income, as defined in subsection 2 of this section;
- 11 (3) Meets the asset limits in subsection 3 of this section;
- 12 (4) Has net income, as defined in subsection 3 of this section, that does 13 not exceed the limit for permanent and totally disabled individuals to receive 14 nonspenddown MO HealthNet under subdivision (24) of subsection 1 of section

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

15 208.151; and

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

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

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

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

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

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

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

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

49 (c) A twenty dollar standard deduction;

50 (d) Health insurance premiums;

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

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

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

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

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

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

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

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

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

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

86 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
2 as "MO HealthNet". For the purpose of paying MO HealthNet benefits and to
3 comply with Title XIX, Public Law 89-97, 1965 amendments to the federal Social
4 Security Act (42 U.S.C. Section 301, et seq.) as amended, the following needy
5 persons shall be eligible to receive MO HealthNet benefits to the extent and in
6 the manner hereinafter provided:

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

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

17 (3) All participants receiving blind pension benefits;

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

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

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

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

35 (8) All participants receiving family foster home or nonprofit private
36 child-care institution care, subsidized adoption benefits and parental school care

37 wherein state funds are used as partial or full payment for such care;

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

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

46 (11) Pregnant women who meet the requirements for aid to families with
47 dependent children, except for the existence of a dependent child who is deprived
48 of parental support as provided for in subdivision (2) of subsection 1 of section
49 208.040;

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

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

61 (14) Children who have attained six years of age but have not attained
62 nineteen years of age. For children who have attained six years of age but have
63 not attained nineteen years of age, the family support division shall use an
64 income assessment methodology which provides for eligibility when family income
65 is equal to or less than equal to one hundred percent of the federal poverty level
66 established by the Department of Health and Human Services, or its successor
67 agency. As necessary to provide MO HealthNet coverage under this subdivision,
68 the department of social services may revise the state MO HealthNet plan to
69 extend coverage under 42 U.S.C. Section 1396a (a)(10)(A)(i)(III) to children who
70 have attained six years of age but have not attained nineteen years of age as
71 permitted by paragraph (2) of subsection (n) of 42 U.S.C. Section 1396d using a
72 more liberal income assessment methodology as authorized by paragraph (2) of

73 subsection (r) of 42 U.S.C. Section 1396a;

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

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

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

96 (18) Pregnant women and children eligible for MO HealthNet benefits
97 pursuant to subdivision (12), (13) or (14) of this subsection shall not as a
98 condition of eligibility for MO HealthNet benefits be required to apply for aid to
99 families with dependent children. The family support division shall utilize an
100 application for eligibility for such persons which eliminates information
101 requirements other than those necessary to apply for MO HealthNet
102 benefits. The division shall provide such application forms to applicants whose
103 preliminary income information indicates that they are ineligible for aid to
104 families with dependent children. Applicants for MO HealthNet benefits under
105 subdivision (12), (13) or (14) of this subsection shall be informed of the aid to
106 families with dependent children program and that they are entitled to apply for
107 such benefits. Any forms utilized by the family support division for assessing
108 eligibility under this chapter shall be as simple as practicable;

109 (19) Subject to appropriations necessary to recruit and train such staff,
110 the family support division shall provide one or more full-time, permanent
111 eligibility specialists to process applications for MO HealthNet benefits at the site
112 of a health care provider, if the health care provider requests the placement of
113 such eligibility specialists and reimburses the division for the expenses including
114 but not limited to salaries, benefits, travel, training, telephone, supplies, and
115 equipment of such eligibility specialists. The division may provide a health care
116 provider with a part-time or temporary eligibility specialist at the site of a health
117 care provider if the health care provider requests the placement of such an
118 eligibility specialist and reimburses the division for the expenses, including but
119 not limited to the salary, benefits, travel, training, telephone, supplies, and
120 equipment, of such an eligibility specialist. The division may seek to employ such
121 eligibility specialists who are otherwise qualified for such positions and who are
122 current or former welfare participants. The division may consider training such
123 current or former welfare participants as eligibility specialists for this program;

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

141 (21) Case management services for pregnant women and young children
142 at risk shall be a covered service. To the greatest extent possible, and in
143 compliance with federal law and regulations, the department of health and senior
144 services shall provide case management services to pregnant women by contract

145 or agreement with the department of social services through local health
146 departments organized under the provisions of chapter 192 or chapter 205 or a
147 city health department operated under a city charter or a combined city-county
148 health department or other department of health and senior services designees.
149 To the greatest extent possible the department of social services and the
150 department of health and senior services shall mutually coordinate all services
151 for pregnant women and children with the crippled children's program, the
152 prevention of intellectual disability and developmental disability program and the
153 prenatal care program administered by the department of health and senior
154 services. The department of social services shall by regulation establish the
155 methodology for reimbursement for case management services provided by the
156 department of health and senior services. For purposes of this section, the term
157 "case management" shall mean those activities of local public health personnel
158 to identify prospective MO HealthNet-eligible high-risk mothers and enroll them
159 in the state's MO HealthNet program, refer them to local physicians or local
160 health departments who provide prenatal care under physician protocol and who
161 participate in the MO HealthNet program for prenatal care and to ensure that
162 said high-risk mothers receive support from all private and public programs for
163 which they are eligible and shall not include involvement in any MO HealthNet
164 prepaid, case-managed programs;

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

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

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

181 by annual appropriation;

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

188 (c) All persons who would be determined to be eligible for permanent and
189 total disability benefits under the eligibility standards in effect December 31,
190 1973, as authorized by 42 U.S.C. Section 1396a(f); or less restrictive
191 methodologies as contained in the MO HealthNet state plan as of January 1,
192 2005; except that, on or after July 1, 2005, less restrictive income methodologies,
193 as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income
194 limit if authorized by annual appropriations. Eligibility standards for permanent
195 and total disability benefits shall not be limited by age;

196 (25) Persons who have been diagnosed with breast or cervical cancer and
197 who are eligible for coverage pursuant to 42 U.S.C. Section
198 1396a(a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of
199 presumptive eligibility in accordance with 42 U.S.C. Section 1396r-1;

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

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

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

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

210 2. Rules and regulations to implement this section shall be promulgated
211 in accordance with chapter 536. Any rule or portion of a rule, as that term is
212 defined in section 536.010, that is created under the authority delegated in this
213 section shall become effective only if it complies with and is subject to all of the
214 provisions of chapter 536 and, if applicable, section 536.028. This section and
215 chapter 536 are nonseverable and if any of the powers vested with the general
216 assembly pursuant to chapter 536 to review, to delay the effective date or to

217 disapprove and annul a rule are subsequently held unconstitutional, then the
218 grant of rulemaking authority and any rule proposed or adopted after August 28,
219 2002, shall be invalid and void.

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

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

248 5. The department of social services may apply to the federal Department
249 of Health and Human Services for a MO HealthNet waiver amendment to the
250 Section 1115 demonstration waiver or for any additional MO HealthNet waivers
251 necessary not to exceed one million dollars in additional costs to the state, unless
252 subject to appropriation or directed by statute, but in no event shall such waiver

253 applications or amendments seek to waive the services of a rural health clinic or
254 a federally qualified health center as defined in 42 U.S.C. Section 1396d(l)(1) and
255 (2) or the payment requirements for such clinics and centers as provided in 42
256 U.S.C. Section 1396a(a)(15) and 1396a(bb) unless such waiver application is
257 approved by the oversight committee created in section 208.955. A request for
258 such a waiver so submitted shall only become effective by executive order not
259 sooner than ninety days after the final adjournment of the session of the general
260 assembly to which it is submitted, unless it is disapproved within sixty days of
261 its submission to a regular session by a senate or house resolution adopted by a
262 majority vote of the respective elected members thereof, unless the request for
263 such a waiver is made subject to appropriation or directed by statute.

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

208.225. 1. To implement fully the provisions of section 208.152, the MO
2 HealthNet division shall calculate the Medicaid per diem reimbursement rates
3 of each nursing home participating in the Medicaid program as a provider of
4 nursing home services based on its costs reported in the Title XIX cost report
5 filed with the MO HealthNet division for its fiscal year as provided in subsection
6 2 of this section.

7 2. The recalculation of Medicaid rates to all Missouri facilities will be
8 performed as follows: effective July 1, 2004, the department of social services
9 shall use the Medicaid cost report containing adjusted costs for the facility fiscal
10 year ending in 2001 and redetermine the allowable per-patient day costs for each
11 facility. The department shall recalculate the class ceilings in the patient care,
12 one hundred twenty percent of the median; ancillary, one hundred twenty percent
13 of the median; and administration, one hundred ten percent of the median cost
14 centers. Each facility shall receive as a rate increase one-third of the amount
15 that is unpaid based on the recalculated cost determination.

16 3. Any intermediate care facility or skilled nursing facility, as
17 such terms are defined in section 198.006, participating in MO
18 HealthNet that incurs total capital expenditures, as such term is
19 defined in section 197.305, in excess of two thousand dollars per bed
20 shall be entitled to obtain from the MO HealthNet division a

21 **recalculation of its Medicaid per diem reimbursement rate based on its**
22 **additional capital costs or all costs incurred during the facility fiscal**
23 **year during which such capital expenditures were made. Such**
24 **recalculated reimbursement rate shall become effective and payable**
25 **when granted by the MO HealthNet division as of the date of**
26 **application for a rate adjustment.**

208.790. 1. The applicant shall have or intend to have a fixed place of
2 residence in Missouri, with the present intent of maintaining a permanent home
3 in Missouri for the indefinite future. The burden of establishing proof of
4 residence within this state is on the applicant. The requirement also applies to
5 persons residing in long-term care facilities located in the state of Missouri.

6 2. The department shall promulgate rules outlining standards for
7 documenting proof of residence in Missouri. Documents used to show proof of
8 residence shall include the applicant's name and address in the state of Missouri.

9 3. Applicant household income limits for eligibility shall be subject to
10 appropriations, but in no event shall applicants have household income that is
11 greater than one hundred eighty-five percent of the federal poverty level for the
12 applicable family size for the applicable year as converted to the MAGI equivalent
13 net income standard. [The provisions of this subsection shall only apply to
14 Medicaid dual eligible individuals.]

15 4. The department shall promulgate rules outlining standards for
16 documenting proof of household income.

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

12 2. The structured family caregiver waiver shall include:

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

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

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

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

25 (5) A limit of three hundred participants to receive structured
26 family caregiving;

27 (6) A requirement that all organizations serving as structured
28 family caregiving agencies are considered in-home service provider
29 agencies and are accountable for documentation of services delivered,
30 meeting the requirements set forth for these provider agencies,
31 qualification and requalification of caregivers and homes, caregiver
32 training, providing a case manager or registered nurse to create a
33 service plan tailored to each participant's needs, professional staff
34 support for eligible people, ongoing monitoring and support through
35 monthly home visits, deployment of electronic daily notes, and remote
36 consultation with families;

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

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

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

50 3. (1) Within ninety days of the effective date of this section, the
51 department of social services shall, if necessary to implement the

52 provisions of this section, apply to the U.S. Secretary of Health and
53 Human Services for a structured family caregiver waiver. The
54 department of social services shall request an effective date before July
55 2, 2020, and shall, by such date, take all administrative actions
56 necessary to ensure timely and equitable availability of structured
57 family caregiving services for home- and community-based care
58 participants.

59 (2) Upon receipt of an approved waiver under subdivision (1) of
60 this subsection, the department of health and senior services shall
61 promulgate rules to implement the provisions of this section. Any rule
62 or portion of a rule, as that term is defined in section 536.010, that is
63 created under the authority delegated in this section shall become
64 effective only if it complies with and is subject to all of the provisions
65 of chapter 536, and, if applicable, section 536.028. This section and
66 chapter 536 are nonseverable, and if any of the powers vested with the
67 general assembly pursuant to chapter 536 to review, to delay the
68 effective date, or to disapprove and annul a rule are subsequently held
69 unconstitutional, then the grant of rulemaking authority and any rule
70 proposed or adopted after August 28, 2019, shall be invalid and void.

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

- 3 (1) Supervising their personal care attendant;
- 4 (2) Verifying wages to be paid to the personal care attendant;
- 5 (3) Preparing and submitting time sheets, signed by both the consumer
6 and personal care attendant, to the vendor on a biweekly basis;
- 7 (4) Promptly notifying the department within ten days of any changes in
8 circumstances affecting the personal care assistance services plan or in the
9 consumer's place of residence;
- 10 (5) Reporting any problems resulting from the quality of services rendered
11 by the personal care attendant to the vendor. If the consumer is unable to resolve
12 any problems resulting from the quality of service rendered by the personal care
13 attendant with the vendor, the consumer shall report the situation to the
14 department; [and]
- 15 (6) Providing the vendor with all necessary information to complete
16 required paperwork for establishing the employer identification number; **and**
- 17 (7) **Allowing the vendor to comply with its quality assurance and**

18 **supervision process, which shall include, but not be limited to, bi-**
19 **annual face-to-face home visits and monthly case management**
20 **activities.**

21 2. Participating vendors shall be responsible for:

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

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

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

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

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

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

48 5. (1) All vendors shall, by July 1, 2015, have, maintain, and use a
49 telephone tracking system for the purpose of reporting and verifying the delivery
50 of consumer-directed services as authorized by the department of health and
51 senior services or its designee. [Use of such a system prior to July 1, 2015, shall
52 be voluntary.] The telephone tracking system shall be used to process payroll for
53 employees and for submitting claims for reimbursement to the MO HealthNet

54 division. At a minimum, the telephone tracking system shall:

55 (a) Record the exact date services are delivered;

56 (b) Record the exact time the services begin and exact time the services
57 end;

58 (c) Verify the telephone number from which the services are registered;

59 (d) Verify that the number from which the call is placed is a telephone
60 number unique to the client;

61 (e) Require a personal identification number unique to each personal care
62 attendant;

63 (f) Be capable of producing reports of services delivered, tasks performed,
64 client identity, beginning and ending times of service and date of service in
65 summary fashion that constitute adequate documentation of service; and

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

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

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

82 [(4)] (3) The department of health and senior services shall promulgate
83 by rule the minimum necessary criteria of the telephone tracking system. Any
84 rule or portion of a rule, as that term is defined in section 536.010, that is created
85 under the authority delegated in this section shall become effective only if it
86 complies with and is subject to all of the provisions of chapter 536 and, if
87 applicable, section 536.028. This section and chapter 536 are nonseverable and
88 if any of the powers vested with the general assembly pursuant to chapter 536 to
89 review, to delay the effective date, or to disapprove and annul a rule are

90 subsequently held unconstitutional, then the grant of rulemaking authority and
91 any rule proposed or adopted after August 28, 2010, shall be invalid and void.

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

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

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

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

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

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

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

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

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

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

25 (1) Demonstrate sound fiscal management as evidenced on accurate
26 quarterly financial reports and **an annual financial statement** audit [submitted

27 to the department] **performed by a certified public accountant if the**
28 **vendor's annual gross revenue is one hundred thousand dollars or more**
29 **or, if the vendor's annual gross revenue is less than one hundred**
30 **thousand dollars, an annual financial statement audit or annual**
31 **financial statement review performed by a certified public**
32 **accountant. Such reports, audits, and reviews shall be completed and**
33 **made available upon request to the department; [and]**

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

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

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

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

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

50 (5) **Maintain a business location which shall comply with any and**
51 **all applicable city, county, state, and federal requirements, verified by**
52 **the Missouri Medicaid audit and compliance unit.**

53 **3. No state or federal funds shall be authorized or expended if**
54 **the owner, primary operator, certified manager, or any direct employee**
55 **of the consumer-directed services vendor is also the personal care**
56 **attendant, unless such person provides services solely on a temporary**
57 **basis for no more than three days in a thirty-day period.**

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

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

6 consumer-direct personal care assistance service;

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (2) Within forty-five days prior to the release of a person who is

22 qualified for suspension under subsection 1 of this section.

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

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

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

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

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

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

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

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