SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 1846

96TH GENERAL ASSEMBLY

5950L.06C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 208.895, RSMo, and to enact in lieu thereof one new section relating to referrals for MO HealthNet home- and community-based care.

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

Section A. Section 208.895, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.895, to read as follows:

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

(1) **[**Review the recommendations regarding services and**]** Process the referral within fifteen business days;

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

(3)**]** Arrange for the provision of services by **[**an in-home**] a home- and community-based** provider;

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

(5) Notify the referring entity upon the authorization of MO HealthNet eligibility and provide MO HealthNet reimbursement for personal care benefits effective the date of the

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

assessment or physician's order, and MO HealthNet reimbursement for waiver services effective the date the state reviews and approves the care plan;

(6)**] (3)** Notify the referring entity within five business days of receiving the referral if additional information is required to process the referral; **[**and

(7) Inform the provider and contact the individual when information is insufficient or the proposed care plan requires additional evaluation by state staff that is not obtained from the referring entity to schedule an in-home assessment to be conducted by the state staff within thirty days**]**

(4) Inform the applicant of:

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

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

(c) The option to choose more than one home- and community-based service provider to deliver or facilitate the services the applicant is qualified to receive and that the applicant has the option to choose an assessment facilitated by a provider or by the state;

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

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

2. If the department does not process a referral or physician's order for MO HealthNet-funded home- and community-based provider care within fifteen business days of receipt by the department, the care plan recommendation of the provider shall become effective thereafter.

3. If the department of health and senior services **[**may contract for initial home- and community-based assessments, including a care plan, through an independent third-party assessor. The contract**] has not complied with subsection 1 of this section, the department** shall **[**include a requirement that:

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

(2) The contractor**]** notify the referring entity **[**within five days**] or individual** of receipt of referral if additional information is needed to process the referral. **[**The contract shall also include the same requirements for such assessments as of January 1, 2010, related to timeliness of assessments and the beginning of service. The contract shall be bid under chapter 34 and shall not be a risk-based contract.

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

4. The provisions of this section shall expire August 28, 2013.**]**

5. At such time that the department approves or modifies the assessment and care plan, the latest approved care plan shall become effective.

6. The department's auditing of home- and community-based service providers shall include a review of client service and provider choice and communication of home- and community-based service provider service options to individuals seeking MO HealthNet services. The department shall also make publicly available a review of its process for informing participants of service options within MO HealthNet home- and community-based service provider services and information on referrals.

7. For purposes of this section:

(1) "Assessment" means a face-to-face review of service options and provider choice with an applicant and:

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

(b) Uses forms provided by the department;

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

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

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

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

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

(c) The physical address and phone number of the client or person needing services. Additional information which may assist the department may also be submitted.

8. The department shall:

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

(2) Make recommendations to the general assembly by January 1, 2013, for the implementation of the automated electronic assessment care plan tool.

9. At the end of the first year of this plan being in effect, the department of health and senior services shall prepare a report for the appropriation committee for health, mental health and social services or a committee appointed by the speaker to review the following:

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

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

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

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

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

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