SECOND REGULAR SESSION

HOUSE BILL NO. 1785

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES BAHR (Sponsor) AND KOENIG (Co-sponsor).

5690L.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 208.895, RSMo, and to enact in lieu thereof two new sections relating to structured family caregiving 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 repeated and two new sections enacted in lieu thereof, to be known as sections 208.895 and 208.896, 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 or a physician's order, the department of health and senior services shall:

(1) Process, review**,** and approve or deny the referral within fifteen business days;

(2) For approved referrals, arrange for the provision of services by a home- and community-based provider **or through structured family caregiving in accordance with section 208.896**;

(3) Notify the referring entity or individual within five business days of receiving the referral if a different physical address is required to schedule the assessment. The referring entity has five days to provide a current physical address if requested by the department. If a different physical address is needed, the fifteen-day limit included in subdivision (1) of this subsection is suspended until the information is received by the department;

(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 **or structured family caregiving in accordance with section 208.896**;

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.

(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 choice of receiving home- and community-based services through structured family caregiving, and that a family caregiver under section 208.896 does not conduct assessments, but that choosing a family caregiver will not delay delivery of services; and**

(d) The option to choose more than one home- and community-based service provider **or a combination of structured family caregiving and home- and community-based service providers** to deliver or facilitate the services the applicant is qualified to receive;

(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 have not selected a provider **or structured family caregiving,** or who have selected a provider **or family caregiver** 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 of health and senior services has not complied with subdivision (1) of subsection 1 of this section, a provider has the option of completing an assessment and care plan recommendation. At such time that the department approves or modifies the assessment and care plan, the care plan shall become effective; such approval or modification shall occur within five business days after receipt of the assessment and care plan from the provider. If such approval, modification, or denial by the department does not occur within five business days, the provider's care plan shall be approved and payment shall begin to the provider based on the assessment and care plan recommendation submitted by the provider.

3. At such time that the department approves or modifies the assessment and care plan, the latest approved care plan shall become effective. If the department assessment determines the client does not meet the level of care, the state shall not be responsible for the cost of services claimed prior to the department's written notification to the provider of such denial.

4. The department shall implement subsections 2 and 3 of this section unless the Centers for Medicare and Medicaid Services disapproves any necessary state plan amendments or waivers to implement the provisions in subsections 2 and 3 of this section allowing providers to perform assessments.

5. The department's auditing of home- and community-based service providers shall include a review of the client plan of care and provider assessments, and choice and communication of home- and community-based service provider service options to individuals

seeking MO HealthNet services. Such auditing shall be conducted utilizing a statistically valid sample. 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.

6. For purposes of this section:

(1) "Assessment" means a face-to-face determination that a MO HealthNet participant is eligible for home- and community-based services 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 **or choosing structured family caregiving** will in no way affect the quality of service or the timeliness of the applicant's assessment and authorization process;

(2) A "properly completed 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 current physical address and phone number of the client or person needing services.

Additional information which may assist the department including contact information of a responsible party shall also be submitted.

7. 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, 2014, for the implementation of the automated electronic assessment care plan tool.

8. No later than December 31, 2014, the department of health and senior services shall submit a report to the general assembly that reviews 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) The department's staffing policies implemented to meet the fifteen-day assessment requirement.

208.896. 1. To ensure the availability of comprehensive and cost-effective choices for MO HealthNet recipients to live at home in the communities of their choice and to receive support from caregivers of their choice, home- and community-based care services shall include an option for structured family caregiving as a covered service, subject to federal approval of any amendments to the home- and community-based waiver which are necessary to implement the provisions of this section.

2. As used in this section and section 208.895, "structured family caregiving" means home- and community-based care services for waiver-eligible MO HealthNet recipients who are at risk for long-term care facility placement or stays and who need comprehensive services in the community as diversionary services, or for individuals who are currently in long-term care facilities and who need home- and community-based care services to transition back into the community.

3. Structured family caregiving shall include:

(1) A choice for participants of qualified, credentialed, and trained caregivers, including family caregivers. All caregivers, including family caregivers, shall complete all required training and meet all applicable credentialing criteria;

(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;

(3) A requirement that all organizations serving as structured family caregiving agencies meet all applicable requirements of a home- and community-based care provider, and are accountable for quality, including qualification and requalification of caregivers and homes, professional staff support for eligible seniors, professional training of caregivers, and deployment of electronic community care records, whenever possible; and

(4) 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.

4. (1) Within thirty days of the effective date of this section, the MO HealthNet division shall, if necessary to implement the provisions of this section, apply to the United

States Secretary of Health and Human Services for an amendment of the home- and community-based waiver for the purpose of including structured family care giving as a covered service for eligible home- and community-based waiver recipients. The division shall request an effective date of not later than July 1, 2015, and shall, by such date, take all administrative actions necessary to ensure time and equitable availability of structure family care giving services for home- and community-based care recipients.

(2) Upon receipt of an approved amended waiver under subdivision (1) of this subsection, the division 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, 2014, shall be invalid and void.

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