This document contains a summary of the public comments collected in response to the Adult Day Care Waiver, Aged and Disabled Waiver and Independent Living Waiver amendment applications. Public comment was taken from July 15, 2017 through August 15, 2017. A notice regarding the amendment applications was posted in the Columbia Tribune, Independence Examiner, Kansas City Star, Springfield News-Leader and The St. Louis Post Dispatch on July 15, 2017. The public comment notice, along with copies of the amended waiver applications were published on the Department of Social Services website on July 13, 2017. A public hearing was held in Jefferson City on July 24, 2017. In addition to the public hearing, the public was informed comments would be accepted through email or by submitting written comments directly to MHD. In accordance with the Centers for Medicare and Medicaid Services (CMS) guidance, the waiver amendment applications were made available for public comment for 30 days after July 15, 2017, to allow all self-advocates, providers and stakeholders an opportunity to provide input to the applications. Paper copies of the amendment applications were made available at the public hearing. The public notice provided the following:

- A summary of changes to the waiver applications
- An address for submission of written and electronic comments
- A deadline for submission of comments
- A letter submitted by a State Representative was read

During the public hearing and comment period, MO HealthNet Division (MHD) and Department of Health and Senior Services (DHSS) received comments from:

- Legal Services of Eastern Missouri
- Southwest Center for Independent Living
- Two (2) Private Citizens
- Fifteen State Legislators
- National Multiple Sclerosis Society
- Paraquad
- Missouri Alliance for Home Care
- Missouri Health Care for All
- On my Own Inc.
- Director of Adult Day Care services, St. Louis MO
- Missouri Adult Day Services Association
- Missouri Health Advocacy Alliance
- Services for Independent Living

The Department's response to the testimony received can be found at the end of this document.

The following represents a summary of testimony received at the public hearing from Attorney at Law, Legal Services of Eastern Missouri (LSEM), which was also followed up with an email summary to MHD.

The effective date in the waiver amendments states the changes will be effective July 1st. The effective date of the waiver amendments may not be retroactive as this is a substantive change to the waiver.

The proposed changes to the HCBS eligibility standards do not comply with federal legal requirements and will have significant adverse financial, social and health consequences for the affected participants and the state. With this change, individuals will be served in more restrictive settings such as hospitals, nursing homes and other institutions. The state does not have adequate plans for a smooth transition for the individuals adversely impacted by the change.

The waiver amendments violate due process for individuals adversely impacted, as there will be no change in their condition. (*Weaver v. Colorado Department of Social Services*)

Increasing point count from 21 to 24 will not save the state money, but shift ineligible recipients to higher cost services such as emergency room visits and hospital stays. Individuals without HCBS services will end up in the nursing home. The individuals cut from services will still need the same services as before to live independently.

The proposed amendment violates the *Olmstead v. L.C.* by not allowing affected individuals to live in the "most integrated setting appropriate to their needs." LSEM recommends the state pursue a Section 1915(i) option to serve individuals.

LSEM requests the state withdraw the amendments.

The following represents a summary of testimony received at the public hearing from Southwest Center for Independent Living, which was also followed up by providing written summary by way of letter.

The level of Care (LOC) change will cause adverse fiscal, economic, social and human affects for the state of Missouri, especially when overlapped with other budget cuts to the Home and Community Based Services (HCBS). They have been inundated with calls from consumers fearful of losing their services. The Department of Health and Senior Services (DHSS) identifies Centers for Independent Living (CIL) as a resource for individuals that are not eligible for services as well as Area Agencies on Aging. However, this is not a realistic or reasonable expectation for CIL to fill in the gap. HCBS are a less costly option for care and support for seniors and people with disabilities. The budget decision made by the Governor to cut services to our most vulnerable was short sighted and harmful, leaving 45 SCIL consumers and nearly 1200 consumers from the other twenty-one CIL's across Missouri without services. This number is much larger statewide across all agencies. Increasing the LOC score to 24 points leaves these individuals without help or hope of living in a community, least-restrictive environment.

With the current assessment tool these individuals are at great risk of losing their services due to ineligibility with no other options for support. This substandard tool increases the risk and likelihood of significant health declines that will increase emergency room visits and hospitalizations. Participants will be forced out of their homes into institutional settings that oppose the values and spirit of HCBS and drives against the June 22, 1999 Olmstead v.L.C Supreme Court decision that made it unlawful to discriminate in violation of Title II of the Americans with Disabilities Act. Holding that entities must provide community-based services first, when such services are appropriate; second, the affected person is in support of community-based services; and lastly, the community-based services can be accommodated reasonably with resources available.

The assessment tool that is currently being used is subjective and ineffective to accurately determine the LOC necessary for functions of daily living based on their ability to perform those functions – not taking into account that an individuals' ability to complete tasks vary from day to day. This is an inaccurate representation and a poor measurement to use when determining the number of hours to authorize for attendant care.

The change in LOC will have a long-term impact to seniors and people with disabilities. The economic impact on revenue and the workforce development is a significant factor that will slow revenue growth for our state and income for our citizens that work in this industry.

We urge CMS reject this request to amend the eligibility requirement.

The following represents a summary of the comments received by email from 2 private citizens:

The cuts to these services for our most vulnerable are uncivilized and completely unacceptable. I object to the cuts with every fiber of my being and demand that the funding be reinstated.

Do not take away the livelihood and funding from 8,000 disabled or elderly Missourians.

The following represents a summary of the written comments received from 15 State Legislators, in which 2 representatives also provided testimony during the public hearing.

The duty of a State Legislator is to ensure that Missourians have access to critical health care needed. It was stated that they do not agree with the Governor's efforts in reducing the Nursing Home Level of Care (LOC) impacting approximately 8,000 Missourians. This action is not supported by either chamber of the general assembly. They expressed their support for House Committee Bill 3 (HCB3) that would have ensured that all Missourians currently receiving critical medical care would have continued receiving services without interruption. Changing the LOC was not the only option to balance the budget; the governor chose to veto HCB3. By increasing eligibility requirement from 21 to 24 points, means that over 8,000 low income seniors, veterans and disabled Missourians will lose care and will no longer be able to live independently. This approach will harm both those receiving care and those who work in health care providing these in-home services.

The cuts are fiscally irresponsible and will lead to more costly hospitalizations, more expensive levels of care down the road and participants will be forced into nursing homes costing the state additional money for care.

The change violates the 1999 Olmstead Supreme Court decision which requires the state to integrate people with disabilities in the community.

The waiver amendments should not be submitted by the state, and if submitted should be denied by CMS, as the MO legislature has found alternative ways to fund the current standards and keep LOC at 21 points. Missouri must have a balanced budget, but cuts should not be at the expense of our most vulnerable citizens.

One Representative voiced concerns specifically regarding participants with HIV/AIDS, indicating a loss in services would render them homeless and affect their health and the health of those who may become infected by them.

The following represents a summary of the comments received from Senior Advocacy Manager of the National Multiple Sclerosis Society.

The proposed waiver amendments will decrease access to services. Personal attendant care services are utilized by participants with Multiple Sclerosis (MS) allowing them to remain independent living in their own home and allow them to maintain a quality of life. MS impacts more than 11,272 individuals in MO. Accessing care that will allow them to remain active and living at home will save money as opposed to living in a nursing home.

The MS Society urges the Director of the MO HealthNet Division to take into consideration the complex health needs of those living with MS in the state and seek solutions rather than reduce access in the waivers.

The following represents a summary of testimony received at the public hearing from Paraquad, which was also followed up by written testimony from President/CEO of Paraquad.

By raising the eligibility standard from 21 points to 24 points, the state will be cutting services for approximately 8,000 individuals who have currently been assessed to be at risk of institutionalization and in need of CDS. Approximately 75 individuals that we serve and 8,000 individuals served throughout the state with disabilities will have their services abruptly ended. People without access to natural supports (neighbors, family) may have difficulty completing activities of daily living, including dressing, bathing and meal preparation.

Those impacted are at risk of deteriorating health or injury, increasing their cost to the paid services system over time. Medical conditions may exacerbate from not having access to assistance with medication, ostomy care and medical care monitoring.

Consumer Directed Services allow individuals to remain living in their own homes instead of more expensive and less desirable nursing homes or institutions and was designed for that purpose. Without necessary supports an individual's functioning may decline in the areas of self-care, functioning and/or health and, over time, would likely require more expensive care.

Consumer Directed Services promotes independent living and consumer control and is in line with the Olmstead decision.

Nursing Homes conduct the initial evaluation to determine eligibility for admission. One presumes nursing homes could be "biased" in the erring on the side of admission. DHSS conducts initial evaluation of consumers prior to their accessing HCBS (to assure that there is no "incentive" to provider.)

Paraquad strongly believes that Missouri should only be supporting policies and laws that create a more robust HCBS program.

The following represents a summary of testimony received at the public hearing from Missouri Alliance for Home Care, which was also followed up by written testimony.

While we understand the budget shortfall in the state of Missouri we do not feel that this is the correct way to solve the issues.

Missouri's system is broken and needs to be fixed. The answer is not to just cut from the bottom of the scale. This process does not ensure that our most vulnerable elderly and disabled will continue to receive the needed services to survive or live independently in their home and community. Missouri's assessment process needs to be reviewed and revised to make sure those that those actually need services receive them and those that no longer require services are removed from the system. A score of 21 does not necessarily mean you can easily go without services.

Budget cuts that require the elderly and disabled to meet a higher point count on the assessment tool will have significant human, financial and social consequences to the State of MO. This change in policy will result in the elimination of home and community based services to over 8,000 elderly and disabled citizens or, 13% of the caseload.

Increasing the point count from 21 to 24 will not save the state money but only shift the need to higher cost services (example: will see an increase in Emergency Room visits, hospital stays and hospital readmissions) Unnecessary ER visits and Hospital readmissions is a nationwide epidemic. HCBS providers are sought out by hospitals to help alleviate this costly issue.

Seniors have worked all their lives and deserve the right to live and receive care in the least restrictive setting.

These services assure the intent of the Olmstead Case and allow them to remain in their home and community rather than seek care in an institutional setting. The state needs to consider the consequences under this federal law.

The following represents a summary of the comments received from Missouri Health Care for All.

The proposed revisions would impact thousands of Missourians with disabilities, resulting in loss of vital services needed for their health and to remain in the community. Many will be at risk of having to receive care in more restrictive settings such as hospitals and nursing homes. We oppose the amendments.

The following represents a summary of the comments received at the public hearing from On my Own Inc., Center for Independent Living.

The transition plan in the waiver amendments indicate the state will provide affected participants with community resources upon request. This is not an adequate transition plan to ensure their health and safety. Resources that would be provided mentioned during legislative testimony included faith based

organizations, family members, and the Missouri Centers for Independent Living. Centers for Independent Living received a 41% cut; we were stretched before the cut, we have had to lay off staff, and we can't pick up the slack.
The Centers for Independent Living do not deliver direct services outside of the HCBS programs.

Churches are not an option for many, as only 65% of the population attends church and most wouldn't feel comfortable receiving personal care. Additionally, many of the participants we serve do not have family members to help them or their family members are working and unable to help.

Without HCBS, participants will go to hospitals and nursing homes. Missouri is at great risk of violating the Olmstead decision as this will result in the institutionalization of citizens.

The following represents a summary of the comments received at the public hearing from Adult Day Care Services, St. Louis, MO.

Adult Day Cares serve many individuals with a developmental disability. These participants impacted may not have the oversight that they need for safety. For example, some of my clients ingest items not meant for human consumption.

Many of the impacted individuals may end up in emergency care. Additionally, families may have to stop working in order to take care of them or put them in facilities that are more costly to the state.

Health care professionals delivering these services may lose their jobs.

The State is looking for a quick fix, but not looking at the long term impact.

The following represents a summary of written testimony received from the Missouri Adult Day Services Association.

Adult Day Care (ADC) providers are keeping individuals out of nursing homes and hospitals and saving the medicaid program and taxpayers money.

Because of the subjectivity of those performing assessments, a person who requires services may in many cases not qualify at 24 points. Yet their need for assistance remains. Many can't even make their own decisions but because they can do a few things unsupervised doesn't mean that they don't need the service.

Due to the increase in points required to qualify for services, it is going to cause people who can't be left alone, to be alone and in danger. It is going to cause ADC providers to lay-off staff due to the decrease in the number of clients which can leave those families destitute. It will also prematurely institutionalize people who are yet viable and contributing members of society. Reimbursement for HCBS services has already been cut by 3% and now the changes to the assessment requiring 24 points will destroy the lives of elderly and disabled people. Due to the additional stress on family caregivers who will no longer get the respite they need by sending their family member to the adult day center, there is potential for adult abuse in the home to increase.

The following represents a summary of written testimony received from Policy and Legislative Affairs of the Missouri Health Advocacy Alliance.

-All three waiver amendment applications include substantial technical deficiencies.
The intent and effect of the proposed waiver amendments is to decrease the number of participants. The only substantive adjustment made to any of the three targeted HCBS programs is to increase the eligibility standard and thereby decrease the number of participants.
On page 2, section B of all three applications, the state has indicated that the "Nature of the Amendment" is "Other." Despite the instruction to "check each that applies" the state does not indicate that the amendments would have any of the following effects: "Modify Medicaid Eligibility," "Add/delete services," or "Increase/decrease number of participants."
The refusal to acknowledge that an increase to the point count would decrease the number of the participants is a patent mischaracterization of the intent and effect proposed waiver amendment.

-The proposed waiver amendments are fiscally irresponsible.

The average cost to the state for an individual enrolled in most HCBS programs is approximately 25% of the cost for an individual receiving similar care as a resident of an institution. Such residential facilities cost approximately $119 per day while CDS services usually cost around $27 per day.

The Missouri Health Advocacy Alliance urges the Missouri Department of Health and Senior Services for to more fully consider the potential disadvantages of the proposed waiver amendments.

Contrary to its assertion on page 6, paragraph E of the applications, the state is not able to assure that the average per capita expenditures under the amended waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the current Medicaid State plan as required by 42 C.F.R. 441.302(e).

Because benefit recipients with point counts between 21 and 23 will no longer be eligible for the targeted HCBS programs, they will be more prone to accidents, falls, and other risks associated with individuals requiring nursing facility level care. Because of this increased risk, those individuals are at risk of incurring greater disability, thereby increasing their point counts beyond what they otherwise might have been. This point count increase will likely result in greater per capita expenditures for the group of HCBS beneficiaries with point counts currently greater than 23.

-The proposed waiver amendments will reduce the effectiveness of the HCBS programs targeted and of Missouri's safety net generally.

HCBS beneficiaries with point counts between 21 and 23 will fall into one of two categories: either they will move in to residential nursing level care facilities or they will not receive the care they require.
The stated vision of MO HealthNet is that "Missouri's low income and vulnerable citizens will have access to excellent health care in order to maximize their quality of life and independence." HCBS programs are specifically oriented to promote that core vision, and few MO HealthNet programs are more effective or cost-efficient than HCBS.

The following represents a summary of written comments received from Services for Independent Living.

We are very concerned with the change to the level of care, which will impact roughly 8,000 individuals statewide.

Our comments are organized by text, comment, and recommendation related to the level of care and the impact on existing and potential Medicaid participants

Text: Brief Description of the Program (starting at page 4). Throughout the waiver application, the term "provider" is used interchangeably with "vendor."

Comment: The term "vendor" is unique to the independent living philosophy, and is defined in Section 208.900, RSMO and 19 CSR 15.00 as "Any person, firm or corporation having a written agreement with DHSS to provide services, including monitoring and oversight of the attendant, orientation and training of the consumer, and fiscal conduit services necessary for delivery of Consumer Directed Services to physically disabled persons.".

Recommendation (s}: Replace the term "provider" with "vendor" to distinguish between the medical model and the independent living model and be consistent with state statute and regulations.

Text: C. Evaluation of Need (page 6): The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in Appendix B.

Comment: Appendix B.a.: Participant Access and Eligibility reflects the maximum number of unduplicated participants to be 600 per year for five years. Our concern is the creation of a wait list, which contradicts the assurance of an initial evaluation. Further, with a limited number of slots, an individual who chose Consumer Directed Services and is over the cost cap (60% of the nursing home cost) has three options, depending on the circumstances: 1) If the consumer is at least 63, they may choose to receive the Aged & Disabled Waiver services; 2) go without services; 3) receive services in the hospital (3 days stay will allow a person in acute condition to enter into the nursing home with a doctor's order). The IL Waiver has an age range of 18 -63, which means consumers must have a false choice to leave the CDS program for In-Home Services. Under Hiltibran v Levy (Case 2:10-cv-04185-NKL), the Missouri District Court asserted "the Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under sections 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition."). Therefore, the Department is at risk of not complying with the Hiltibran decisions unless Medicaid participants have access and authorizations for incontinent supplies through the Independent Living Waiver. If a consumer chooses In-Home Services, they may also be required to change from a CDS vendor to an In-Home provider since many CDS vendors are not a qualified provider. Further, the In-Home

Services aide cannot be related by blood, adoption, or marriage, which means another false choice must be made when transferring to an In-Home Services program. The Social Security Act and the Home and Community Based Services Rule mandate choice, including from whom they receive services.

Recommendation(s}: We recommend changes to the applicable laws, regulations, and policies to waive training requirements of a currently employed CDS personal care attendant, which would satisfy the federal mandate of "choice" and the Home and Community Based Services rule. The waiver would also increase employability of a personal care attendant whose consumer had the option of entering an institution for care or whose services would be eliminated due to the 60% cost cap of the CDS program. We also recommend the Department to decide how to comply with Hiltibran.

Text: Attachment 1: Specify the transition plan for the waiver (page 10). As participants are reassessed, and it is found they no longer are Nursing Facility Level of Care eligible, each participant will be provided with a notice of adverse action explaining the reason for the closing of their services. Additionally, upon request, participants will be provided with information regarding community options and resources to assist them in making contacts to find other supportive services to remain independent.

Comment: The community integration mandates state and local governments to "administer services, programs, and activities in the most integrated setting appropriate" to the needs of people with disabilities. Our concern with providing information regarding community options is the lack of resources, especially in the very rural areas. Numerous participants forego services because the workforce is currently inadequate to meet the need. Increasing the level of care will result in a substantial loss in the quality of life and interactions in the community to the fullest extent possible. The loss of home care increases the potential risk to the health, safety, and welfare of an individual. We fear this will lead to increased hotline calls, probate cases, and institutionalization. The burden of information is also heavily reliant upon the participant's knowledge to make a request.

Recommendation(s): We recommend the Department develop resources to distribute to each participant after the assessment and ineligibility; metrics are developed to measure the availability and effectiveness of the resources; and metrics are developed to measure the number of falls, hospitalizations, and institutionalizations, caused by the increased level of care.

Text: C. Evaluation of Need (Appendix B.b.) (page 42): Individuals are enrolled based upon the individual meeting the nursing home level of care and criteria specific in this waiver. A high level of unit authorization is representative of individuals who have the greatest need in the State. In the event all slots are filled during a waiver year, priority of available slots will be given to those with the greatest need. Individuals will be enrolled based upon the number of potential units authorized in the task areas listed below, with the largest potential number of units indicating the highest level of need. If individuals have the same level of potential authorized units in the task areas listed below, the date of referral will be used. [Areas are listed]: Bathing, Bowel/Bladder Routine, Catheter Hygiene, Ostomy Hygiene, Meal, Prep/Eating, Turning/Positioning, Assist with Toileting, Bathing, Dressing/Grooming, Assistive with Transfer Device, Mobility/Transfer.

Comment: Section 208.903, RSMO, mandates that a potential consumer "Participates in an assessment or evaluation, or both, by the department" to determine unmet needs are identified prior to the development of a Care Plan. Section 208.900, RSMO defines unmet need as "routine tasks and activities of daily living which cannot be reasonably met by members of the consumer's household or other current support systems without causing undue hardship. Further undue hardship is defined to include "loss of consumer's income; overall disintegration of the family; abuse and neglect; misuse of child labor; and/or presence of physical contraindications." We acknowledge that a high level of units authorized can represent a great need. However, the unmet needs are the prevailing factors for determining the level of care and services required. We are concerned how the priority is defined, which is contrary to state statute and the assessment tool (lnterRAI).

Recommendation(s): We recommend the level of care remain at 21 during the interim period of the Centers for Medicare and Medicaid (CMS) review to determine whether the maximum number of slots available meet federal and state law, including the Americans with Disabilities Act and the U.S. Supreme Court Olmstead decision. We also recommend the lnterRAI be modified to implement the exclusionary rule ("but for") to support the provision of home and community-based services under a waiver (42 CFR Part 11, Subpart G) when otherwise a participant would require institutionalization. We highly recommend priority of need considering employed individuals to support continued employment.

Text: Provider Qualifications: Case Management (page 61); FMS (page 66): Demonstrate sound fiscal management as evidenced on accurate quarterly financial reports and annual audit submitted to the department.

Comment: An accurate quarterly financial report does not necessarily demonstrate sound fiscal management, especially considering the data that is reported. Further, unless a vendor is a corporation or not-for-profit organization, an annual audit is generally not performed.

Recommendation(s): We recommend the level of care remain at 21 during the interim period of CMS review to review and modify financial reporting requirements, the quarterly financial report, and the validation process required by the Department.

Appendix D: Participant-Centered Planning and Service Delivery. Risk assessment and mitigation (page 84): During the assessment, evaluation and care planning process risks are assessed such as identifying support systems or lack thereof, and confusion factors. Once the assessment/evaluation process identifies possible risk factors and needs, a determination is made as to whether or not these factors will be alleviated through service planning, or if referrals should be made to and coordinated with other community supports.

Comment: We are concerned how risks will be mitigated when other community supports are unavailable or the participant is ineligible for those identified resources. The listing of resources distributed to the general assembly contained three resources: 211 (United Way), Centers for Independent Living, and Area Agencies on Aging. Other resources are expected to include places of worship and neighbors. Centers for Independent Living are contractors of Medicaid services, and are obliged to charge no less than the current Medicaid rate for services, which is unfeasible for most

Medicaid participants. Further, Centers for Independent Living received a 44% cut in general revenue, which has substantially impacted our sustainability. The remaining resources: 211 and Area Agencies on Aging do not provide direct service, and their resources are also limited. The expectation to approach a church member or a neighbor for assistance with personal care deteriorates the current relationship and causes concern about dependability.

Recommendation(s): We recommend that resources are developed and reviewed by the Department of Health and Senior Services, Division of Senior and Disability Services prior to assessments being performed. We also recommend the resources are verifiable, reliable, and available in the community where the participant lives. Further, we recommend metrics are developed to verify assurances to CMS have been met.

Text: Participant-Centered Planning and Service Delivery: Service Plan Implementation and Monitoring (b) (page 86): DSDS contact new waiver participants within 10 days of the prior authorization date to ensure that the services have begun and meet the participant's needs. The waiver provider is required to ensure prompt initiation of authorized services, not to exceed seven (7) days of the prior authorization date.

Comment: According to Section 208.909, RSMO, a participant in the Consumer Directed Services/Independent Living Waiver is the employer, whose responsibility includes recruiting, hiring, training, and discharging a personal care attendant. The vendor assists the employer with independent living skills training regarding how to manage their program and personal care attendants. Therefore, if the CDS participant fails to initiate services within a 10-day timeframe, the vendor may assume a joint employer role, which fundamentally alters the program. State statute nor regulations require a timeframe for Independent Living Waiver services to be initiated, although this requirement is relative to In-Home Services.

Recommendation(s): We recommend this text be removed from the waiver application as the waiver vendor is not required to initiate services within a specified timeframe.

Text: Appendix E: Participant Direction of Services. Payment for FMS (ii) (page 105): Payment for FMS. The reimbursement rate for FMS provided through the ILW is based on cost analysis associated with the provision of this service. In addition, industry standards and information from other states for reimbursement of FMS was considered. Missouri also consulted with ILW providers regarding costs associated with FMS.

Comment: It is crucial for the Department and all key FMS vendors to clearly understand the principles of the cost management and profitability analysis process. The analysis in which the costs were determined cannot solely be based upon industry standards and information from other states. The method to determine the reimbursement rate must also take into consideration the statutory and regulatory tasks associated with the program. Services for Independent Living was not consulted with regard to the associated costs with FMS.

Recommendations: We recommend that costs analysis include insights into direct and indirect fixed costs and into direct and indirect variable costs. Further, to ensure accuracy and validation of reporting, we recommend modifications are made to the Quarterly Financial Report, which will also create transparency on the method in which the reimbursement rate is determined.

Text: Appendix I: Financial Accountability: Rates, Billings, and Claims (a. Rate Determination Methods) (page 133): The personal care service rate is based on 2 factors; the attendant's wages and applicable employer taxes. The personal care service rate is based on Missouri's Department of Labor and Industrial Relations CY 12 Average Wage for Personal Care and Service Workers plus all employer related taxes associated with the wage. Providers of Financial Management Service (FMS) act as agents on behalf of the participant and are responsible for all employer and employee payroll functions and requirements.

Comment: Outdated information (CY 12) is used in determining the reimbursement rate. Missouri statute, regulations, and Home and Community Based Services Policy 3.55 require FMS vendors to perform a substantial amount of administrative tasks on behalf of the participant. Additionally, the current methodology provides no real insight into how the Department arrived at the reimbursement rates.

Recommendation(s): We recommend the service rate consider the most current information from the Missouri Department of Labor and Industrial Relations. We also recommend the Department to consider direct and indirect (fixed and variable) costs for rate determination. Further, we recommend the state to review the costs associated with the program by actual FMS vendors instead of using their method of determining by "using 49%, which is the amount used by Department of Health and Senior Services to estimate the fringe benefit costs for its employees [and estimating] administrative cost was calculated at 22.5% of the Personnel and Fringe Benefits costs." Actual costs for FMS vendors should be a prime consideration for establishing the reimbursement rates, although gathering the information may be labor intensive.

Text: Appendix I: Financial Accountability: Rates, Billings, and Claims (a. Rate Determination Methods) (page 133): The reimbursement rates for the Independent Living Waiver (ILW) services are based on the following factors; the Missouri hourly minimum wage, gas prices per gallon for the Midwest, the hourly amount for ILW services, the Consumer Price Index, in addition to the complex care needs of ILW participants. The reimbursement rate is subject to, and determined by, the State Legislature through the State of MO annual budgeting/appropriation process. Participants and business entities are able to testify at annual appropriation hearings conducted by the State House of Representatives and State Senate appropriation committees to provide input on reimbursement rates.

Comment: The ILW reimbursement rate ($3.57) is lower than the rate for Consumer Directed Services ($3.89/unit), and substantially lower compared to In-Home Services: Personal Care/Homemaker ($4.47 /unit); and In-Home Services: Advanced Personal Care (APC) ($5.53/unit). The IL waiver provides participant-directed Advanced Personal Care, but not reimbursed at a comparable to the In-Home APC (unit cost= $3.57 vs. $5.53). Although services are comparable, the Consumer Directed Services'

reimbursement rate was reduced to 60% of the nursing facility cost cap. However, APC under the In-Home Services model remains funded at 100% of the nursing facility cost cap. Although there was a Senate amendment to create equivalent reimbursement rates between the programs, the amendment failed. Further, the complex care needs of ILW participants are equivalent to an individual on the In-Home Services program. The listing of factors seem abstract in relation to setting the reimbursement rate, especially since ILW attendants are reimbursed by the consumer, not the vendor nor state of Missouri.

Recommendation(s): We recommend a review of the ILW reimbursement rate to consider the "complex care needs of ILW participants" according to the Department. Further, we recommend that a waiver based on experience be executed to allow an experienced personal care attendant to qualify for providing In-Home Services APC for the existing consumer, for whom the personal care attendant works. This will require a regulation and policy change, but also protects the participant's federally mandated protection of choice.

Conclusion:

We believe there are alternate opportunities to assess Home and Community Based programs and services to eliminate potential harm to numerous individuals who do not have access to informal supports or will have to make life-changing decisions. It is crucial for the process to assess and mitigate risks to avoid institutionalization, unless it is the last resort. The Olmstead Court concluded that the "[u]justified institutional isolation of persons with disabilities is a form of discrimination." The Court based its conclusion on two judgments made by Congress in enacting the ADA. First, Congress recognized that the "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Second, Congress asserted that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." In enacting the ADA, Congress sought to eliminate disability-based discrimination and promote the integration of people with disabilities in the community. Compounded with the 60% cost cap of the Consumer Directed Services program and that all 600 waiver slots are now committed, we are extremely concerned of the impact on the consumer if informal supports are unavailable and they lack the resources to assist them to remain in the community. Increase in the level of care is a dangerous cost containment method, and urge the Department and Centers for Medicare and Medicaid to consider the potential risk of creating wait lists and the life-changing decisions that will occur based on the increased level of care.

Department of Health and Senior Services response to testimony received:

1. Regarding the effective date of the waiver amendment, the department acknowledges the date of July 1, 2017 in the amendments is an error, and intends for the effective date to be the date of CMS approval of the respective amendments.
2. Testimony received from three organizations was not directly related to amendment language. The State will evaluate these comments and consider any necessary changes for the next waiver application.
3. The remaining comments were related to the amendment language; however, the State does not intend to make any changes to the waiver amendments.