Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
Significant changes were made to this waiver. The State removed Basic Block Respite, Advanced Block Respite, Advanced Daily Respite and Nurse Respite as services. Current participants receiving Basic Block Respite, Advanced Block Respite and Advanced Daily Respite will be transferred to Basic Respite or Advanced Respite services, which are delivered in 15 minute units with no specified time restrictions. Participants receiving Nurse Respite services will now be covered by Exceptions through the MO HealthNet Division. These participants will not experience any interruption in services.

Performance measures and other applicable waiver sections were updated by adding, modifying, or deleting performance measures. Other applicable areas in the waiver application were edited in order to ensure compliance with the Final Rule released by the Centers for Medicare and Medicaid Services (CMS).

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Missouri** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Aged & Disabled Waiver

C. Type of Request: renewal

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MO.0026
Draft ID: MO.014.08.00

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*

07/01/18

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- [ ] **Hospital**

  Select applicable level of care

  - ( ) **Hospital as defined in 42 CFR §440.10**
    If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
  - ( ) **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**
- [x] **Nursing Facility**

  Select applicable level of care

  - (•) **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
    If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
  - ( ) **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
- [ ] **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

  If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- (•) **Not applicable**
- ( ) **Applicable**

  Check the applicable authority or authorities:

  - [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
  - [ ] **Waiver(s) authorized under §1915(b) of the Act.**

    Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

    Specify the §1915(b) authorities under which this program operates *(check each that applies):*

    - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
    - [ ] **§1915(b)(2) (central broker)**
    - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
    - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
  - [ ] **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
Purpose: The Aged and Disabled Waiver was developed to provide community-based alternatives to aged individuals and physically disabled individuals 63 and 64 years of age who otherwise would be institutionalized in a nursing facility.

Goal: Establish and maintain a community-based system of care/services for aged individuals and individuals 63 and 64 years of age and higher who have physical disabilities that live and wish to continue living independently in their or their family's homes and to continue to enjoy the amenities available in their communities.

Objectives: 1) provide the targeted group of individual choice between nursing facility care and services that allow them to remain in their home and community in a cost effective manner, and 2) maintain and improve a community based system of care that diverts individuals from institutional care and residential care.

Organizational Structure: The Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS) administers and operates the waiver through a formal Memorandum of Understanding (MOU) with the State Medicaid Agency, the Department of Social Services (DSS), MO HealthNet Division (MHD) that outlines specific duties related to the administration, operation, and oversight functions of the waiver. DSDS provides the direct administrative functions required for the operation of the waiver. In accordance with 42 CFR §431.10, MHD exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver through review and oversight. More specific roles and responsibilities of each agency are specified throughout the waiver application and in the MOU which is available to the Centers for Medicare and Medicaid Services (CMS) upon request through the State Medicaid Agency.

Service Delivery Methods: State staff prior authorize waiver services. Services are delivered by providers who have a participation agreement (contract) with the DSS, Missouri Medicaid Audit and Compliance Unit (MMAC) as an Aged and Disabled Waiver (ADW) provider. Waiver services are prior authorized and claims for reimbursement are filed directly with the Medicaid Management Information System (MMIS) fiscal agent for processing and payment. MHD reimburses enrolled waiver providers directly.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect,

applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may

elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: 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**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for

this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further

bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
Comments and recommendations are obtained from/through the Missouri Alliance for Home Care, Missouri Council for In-Home Services, the Department of Health and Senior Services' Board of Senior Services, and participant feedback through Division of Senior and Disability Services' and DSDS Bureau of Home and Community Services field staff.

The Department of Social Services (DSS), MO HealthNet Division (MHD) publishes notice of new waiver or waiver amendment applications on the MHD website with a link to review the entire waiver application. MHD also publishes notice of waiver application in the five newspapers in Missouri with the greatest population. The notices published on the website and in the newspapers notify the public of upcoming public forums. The public forums take place in a public place. Public may attend the forums in person or via conference call/telephone line. Copies of the waiver application are available during the public forums or they may be accessed online. Once the notice is published in the newspapers and on the MHD website, the public has 30 days to either mail or email comments to MHD. MHD and the Department of Health and Senior Services (DHSS) considers all comments and makes a determination as to whether or not changes are required in the waiver application. If changes are required, they will be made to the waiver application.

There are no federally-recognized tribes in the state of Missouri.

The following is a summary of the public comments collected in response to the

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Glenda

First Name: Kremer

Title:	Assistant Deputy Director
Agency:	Missouri Department of Social Services, MO HealthNet Division
Address:	615 Howerton Court
Address 2:	PO Box 6500
City:	Jefferson City
State:	**Missouri**
Zip:	65102-6500
Phone:	(573) 751-9290 **Ext:** ☐ **TTY**
Fax:	(573) 526-4651
E-mail:	Glenda.A.Kremer@dss.mo.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Jessica
First Name:	Bax
Title:	Deputy Director, Bureau of Long Term Services and Supports
Agency:	Department of Health and Senior Services, Division of Senior and Disability Services
Address:	912 Wildwood
Address 2:	PO Box 570
City:	Jefferson City
State:	**Missouri**
Zip:	65102-0570
Phone:	(573) 526-8557 **Ext:** ☐ **TTY**
Fax:	(573) 522-3024
E-mail:	Jessica.Bax@health.mo.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Tidaball

First Name: Jennifer

Title: Acting Director

Agency: Department of Social Services, MO HealthNet Division

Address: 615 Howerton Court

Address 2: P.O. Box 6500

City: Jefferson City

State: **Missouri**

Zip: 65101

Phone: (573) 751-6922 **Ext:** ☐ ☐ **TTY**

Fax: (573) 751-6564

E-mail: Debbie.Meller@dss.mo.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that the settings transition plan included with this waiver will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.
Missouri administers Home and Community-Based Waivers through the single State Medicaid agency, the Department of Social Services (DSS), MO HealthNet Division (MHD). The day-to-day operation of the Waiver is through a formal cooperative agreement with the Missouri Department of Health and Senior Services (DHSS). The DHSS is the operational entity for the waiver. Missouri Medicaid Audit and Compliance (MMAC) is the unit within the DSS charged with administering and maintaining Medicaid Title XIX audit and compliance initiatives, including utilization of Medicaid services and provider enrollment functions. MMAC will participate in the transition plan as described below.

The formal cooperative agreement outlines specific duties related to the administration, operation and oversight functions of the waiver. The Medicaid Agency has ultimate administrative authority and oversight responsibility for the waivers. All official correspondence including this transition plan, waiver submissions and waiver amendments are developed by, jointly developed, or reviewed by the Medicaid Agency prior to submission to the Centers for Medicare and Medicaid Services (CMS). Any changes to a waiver program must be approved by the State Medicaid Agency. Oversight meetings are held quarterly to discuss waiver functions. The CMS Final Rule, including the activities listed in the transition plan, will be discussed quarterly during the oversight meetings. In addition to the quarterly oversight meetings, staff meets when situations arise that warrant discussion between agencies.

The transition plan incorporates all DHSS waivers and has been jointly developed by the DSS/MHD and the DHSS. The transition plan as outlined below apply exclusively to waivers operated by DHSS.

The transition plan incorporates all DHSS waivers and has been jointly developed by the DSS/MHD and the DHSS. The transition plan as outlined below apply exclusively to waivers operated by DHSS.
• Adult Day Care Waiver (MO.1021)

o All services in the Adult Day Care Waiver (ADCW) are received and administered in an Adult Day Care. The ADCW provides adult day care for individuals age 18-63 with physical and other disabilities. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

• Aged and Disabled Waiver (MO.0026)

o All services in the Aged and Disabled Waiver (ADW) are received and administered in the participant's home or in an Adult Day Care. The ADW provides adult day care, basic respite care, homemaker services, advanced respite care, chore

services, and home delivered meals for aged individuals ages 65 and over and for those who are physically disabled ages 63 and 64. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

• Independent Living Waiver (MO.0346)

o All services in the Independent Living Waiver (ILW) are received and administered in the participant's home. The ILW provides case management, personal care, Financial Management Services (FMS), environmental accessibility adaptations, and specialized medical equipment and supplies for physically disabled individuals ages 18-64. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

Missouri's Transition Plan work has focused on engaging stakeholders to be supported in exploring different avenues, learning experiences, and opportunities to know what is out in the community through education and training on rule requirements, as well as soliciting feedback on Missouri-specific approaches to assessments and compliance; building tools to assess HCBS Final rule compliance among HCB settings and for State regulations, policies, and procedures; utilizing those tools to assess HCB settings; and mapping a path to work toward full compliance by March 2019 and beyond.

Missouri Home and Community-Based Services (HCBS) 1915(c) Waiver Settings Statewide Transition Plan March 14, 2015 Amended July 27, 2016.

Missouri administers Home and Community-Based Waivers through the single State Medicaid agency, the Department of Social Services, MO HealthNet Division (MHD). The day-to-day operation of the waivers is through a formal cooperative agreement with the Missouri Department of Health and Senior Services (DHSS). The Department of Health and Senior Services is the operational entity for the waiver.

MHD submits this amended Statewide Transition Plan in accordance with requirements set forth in the CMS HCBS Final rule released on January 16, 2014 (see 42 C.F.R. § 441.301(c)).

This amended Statewide Transition Plan builds on the originally proposed Statewide Transition Plan submitted on March 14, 2015. This plan includes information submitted in response to the CMS Letter of Reaction, and further details about settings and assessment validation based on conference calls held with CMS on September 15, 2015, and March 17, 2016. Additionally, it reflects guidance that continues to be issued by CMS, including but not limited to the Settings Requirements Compliance Toolkit and the HCBS Training Series Webinars Presented During SOTA Calls (Home and Community-Based Settings, Excluded Settings, and the Heightened Scrutiny Process – November, 2015; and Home and Community-Based Setting Requirements: Systemic and Site-Specific Assessments and Remediation – December, 2015). Due to the need to renew the DHSS Adult Day Care Waiver MHD submitted and received approval for Transition Plans specific to the waiver application. Transition Plan activities were designed to lead to both a waiver-specific Transition Plan for each waiver program as well as a Statewide Transition Plan (STP). Missouri's originally proposed STP and approved waiver-specific Transition Plans differ from this amended STP in the areas specified below:

• Section 1: Assessment: This amended STP provides more detail on the following components:
o General Settings categories with estimated number of settings falling under each category
o Determination of Heightened Scrutiny settings,
o Assessment tool development,
o Systemic Initial On-Site Assessment process including amounts and process of on-site assessments performed,
o On-going monitoring through incorporating the HCBS requirements into existing quality integrated functions, and
o Provider self-assessment and participant survey development.
• Section 2: Remediation Strategies: This amended STP provides more detail on the following components:
o Code of State Regulations Review and Rule filing, including a crosswalk to the HCBS final rule,
o Incorporating HCBS final rule into
• Provider Manuals and Provider Enrollment processes,
• Provider meetings and trainings;
• Processes for provider remediation and status updates,
• On-going compliance reviews, provider sanctions; and

• Individuals transitioning to settings that align with HCBS Requirements
• Section 3: Public Comment: This amended STP provides more detail on the following components:

o Incorporating new public comment processes and periods
Section 1: Assessment

The State used a multi-faceted approach to assessment. This approach included a review of state regulations, policies, procedures, provider manuals, enrollment processes and tools, provider review processes and quality review tools. It also included the development and completion of a settings analysis, provider self-assessment and participant survey. The detailed assessment processes are described below. Assessment activities will be incorporated into current quality assurance processes to the extent possible.

Missouri Code of State Regulation (CSR) Assessment

MHD requested DHSS to review all state regulations to determine their compliance with the HCBS Final rule and if revisions are needed to reflect federal regulations on HCBS settings. This review process took place between October 1, 2014 and March 1, 2015 and continues as needed. DHSS developed a crosswalk documenting their assessment of state regulation compliance with the HCBS Final rule. The crosswalks documents the following information: state regulations; applicable federal requirements; compliance status (compliant, partially compliant, non-compliant or silent); changes needed to bring language into compliance; remediation activities the state will take to bring regulation(s) into compliance; and milestone dates. MHD reviewed each crosswalk and evidence of compliance to ensure that all aspects of the system are congruent with CMS expectations and will allow the State to operate HCBS programs in a manner that comports with the HCBS Final rule. This assessment process involved reviewing state regulations concerning MHD and DHSS located in: Missouri 13 CSR 70, Missouri 13 CSR 65-2, Missouri 19 CSR 15, Missouri 19 CSR 30-81, and Missouri 19 CSR 30-90.

DHSS's systemic CSR review included regulations concerning licensure, provider enrollment, and standards for community-based services. DHSS also reviewed all waiver policies and manuals. The crosswalk can be found at: http://health.mo.gov/seniors/hcbs/transitionplan.php
Provider Manuals, Policies, and Procedures Assessment

MHD requested DHSS and MMAC to review all manuals, policies, and procedures to determine compliance with the HCBS Final rule and if revisions are needed to reflect federal regulations on HCBS settings. This review process began on January 1, 2015 and will be completed December 31, 2016. DHSS developed a crosswalk documenting their assessment of provider manuals, policies, and procedures compliance with the HCBS Final rule. The crosswalk documents regulations that are (a) compliant, and evidence of that compliance; (b) where modifications are needed to achieve compliance, or (c) silent. The crosswalks included the following information: state regulations; applicable federal requirements; compliance status (compliant, non-compliant or silent); changes needed to bring language into compliance; remediation activities the state will take to bring provider manuals, policies, and procedures into compliance; and milestone dates. MHD reviewed each crosswalk and evidence of compliance to ensure that all aspects of the system are congruent with CMS expectations and will allow the State to operate HCBS programs in a manner which comports with the HCBS Final Rule. Results of the crosswalk are posted online at http://health.mo.gov/seniors/hcbs/transitionplan.php.

Missouri HCBS Waiver Participant Survey

The State developed initial participant surveys between November 1, 2014 and December 31, 2014. The surveys were developed utilizing a modification of the CMS exploratory questions along with input from self-advocates. The surveys collected individual experiences to determine if service settings were in compliance with the HCBS Final rule. The surveys included identification of the setting type, so the State could utilize this information in follow-up to the setting. The surveys provided the option for anonymity or to include contact information if participants wished to have follow-up communication with the State. The State did an on-site assessment if requested, or if it was determined there was a need for one, based on the information provided.

DHSS mailed a survey to all participants receiving adult day care services. The surveys included postage-paid return envelopes. The survey is also available on the DHSS Settings website at:
http://health.mo.gov/seniors/hcbs/transitionplan.php.
On an ongoing basis, questions posed from the participant surveys will be incorporated into annual assessments and reviews.
• Adult Day Care Setting. The participant survey utilized by the Division of Senior and Disability Services (DSDS) was an information gathering tool for initial guidance on participant perspective regarding the compliance of the adult day care setting with the elements of the HCBS Final Rule and will be incorporated into the annual reassessment on an on-going basis. The participant survey report can be found at: http://health.mo.gov/seniors/hcbs/transitionplan.php .

• All participants authorized for HCBS shall have a reassessment completed within 365 days of the last level of care determination. For participants receiving an Adult Day Care service, DSDS or its designee shall perform face-to-face reassessments with the participant utilizing the InterRAI HC and the HCBS Care Plan and Participant Choice Statement (DA-3) to establish continued eligibility of services and compliance with the HCBS Settings Rule.

o The InterRAI HC guides comprehensive care and service planning in community-based settings. It focuses on the person's function and quality of life by assessing needs, strengths, and preferences.

o The HCBS Care Plan and Participant Choice Statement (DA-3) is completed at each initial and subsequent face-to-face reassessment and used to determine eligibility for HCBS. As a component of the person centered care planning process the DA-3 provides documentation of the participant's involvement in care planning by including the participant's acknowledgement and outcome of his/her:

• Participation in the development of the person-centered care plan –to include both formal and informal services identified to live successfully in the community

• Right to have anyone involved in the development of the person centered care plan

• Right to choose and receive HCBS (State Plan and/or Waiver) or nursing facility care

• Right to choose the HCBS provider

• Need to Notify the DHSS's Central Registry Unit (CRU) to report abuse, neglect, or exploitation

• Need to notify the appropriate DSDS Regional Evaluation Team of any problems concerning service delivery as well as changes in health, formal and informal supports, satisfaction with the services provided, and/or functioning status that might require care plan adjustment

• Discriminatory behavior regarding service delivery

The InterRAI HC assessment and the HCBS Care Plan and Participant Choice Statement (DA-3) fulfill the non-residential requirements set forth in:

42 CFR 441.301(c)(4)(i)/441.710(a)(1)(i)/441.530(a)(1)(i)
42 CFR 441.301(c)(4)(ii)/ 441.710(a)(1)(ii)/441.530(a)(1)(ii)
42 CFR 441.301(c)(4)(iii)/ 441.710(a)(1)(iii)/441.530(a)(1)(iii)
42 CFR 441.301(c)(4)(iv)/ 441.710(a)(1)(iv)/441.530(a)(1)(iv)
42 CFR 441.301(c)(4)(v) 441.710(a)(1)(v)/441.530(a)(1)(v)

• All other waiver settings are considered compliant, because participants live in their own homes. Therefore, surveys will not be released for those settings unless information is received that the setting may be institutional in nature.

Provider Self-Assessments

On June 23, 2014, the State posted a Provider Bulletin on the MHD website, regarding the HCBS Final rule, including a link to the CMS HCBS website. The bulletin included information alerting providers to a future provider self-assessment survey. The State developed initial provider self-assessment surveys between June 23, 2014 and August 22, 2014 by incorporating the CMS exploratory questions into an on-line survey. Via Provider Bulletin on August 22, 2014, MHD requested HCBS Waiver providers complete an initial provider self-assessment survey by September 10, 2014. In an effort to assist providers with the completion of the provider self-assessments, the State released the "Missouri Exploratory Questions for Assessment of HCBS Waiver Settings" document to assist providers in identifying if services are integrated in and participants have access to supports in the community, including opportunities to seek employment, work in competitive integrated settings, engage in community life, and control personal resources.

MHD requires DHSS to monitor the self-assessment process for each agency and utilize the process for ongoing compliance efforts. This process began on October 1, 2014, and its design was completed by February 1, 2015. This process will continue on an ongoing basis.

o MMAC will continue to assess providers on an ongoing basis, including continued utilization of the Provider Self-Assessment. The provider self-assessment will continue to be utilized in the following ways:

• The provider self-assessment is available on the MMAC website at http://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/ for all prospective and currently enrolled providers to utilize at any time.

• The provider self-assessment will be utilized as a pre-enrollment screening tool when MMAC conducts pre-enrollment on-site visits of Adult Day Care providers.

• The provider self-assessment will be utilized as a regular tool when MMAC conducts post-payment reviews of Adult Day Care providers. MMAC conducts post-payment reviews of enrolled HCBS providers at least every three (3) years.

• The provider self-assessment will be utilized as a regular tool when MMAC conducts revalidation efforts for Adult Day Care providers. MMAC revalidates providers every five years.

• In addition, MMAC will utilize the provider self-assessment when it is on-site with an Adult Day Care provider for other reasons such as investigations, and

• MMAC will utilize the provider self-assessment as a training tool every six months at Provider Update Training.

• MMAC will compare providers' self-assessments and any MMAC observations with participant responses to DHSS' participant assessments and surveys. Any discrepancies will be followed up by the means necessitated by the level of concern (e.g. an on-site visit with the provider, an audit of the provider's billing and practices, or an investigation.)

Settings Analysis

Prior to conducting on-site assessments, the State identified HCBS Waiver settings used by waiver participants. The state conducted a preliminary analysis of these various settings. This Settings Analysis was general in nature and did not imply that any specific provider or location was noncompliant solely by classification. Final determination depends upon information gathered through all assessment activities outlined in the transition plan.

Settings Assessed:

o Adult Day Care, provided in the Adult Day Care and Aged and Disabled Waivers

General settings are classified into the following categories:
• Yes - Settings presumed fully compliant with HCBS characteristics. The State considers settings where individuals own or lease their homes, or reside with family as fully compliant unless information is provided that would lead the State to believe the setting is institutional in nature. The State would then move the setting to the Heightened Scrutiny review. It is assumed that approximately 13,269 DHSS settings will fall into the "Yes" category.
• Not Yet - Settings may already be compliant, or with changes will comply with HCBS characteristics. The State considers settings where individuals reside in provider-owned or controlled housing of any size, reside in a staff member's home, adult day care program settings, or receive services in a day program setting located in a building that also provides other disability-specific services as not yet compliant but may be with changes. It is anticipated that approximately 79 DHSS provider settings will fall under this category.
• Not Yet - Settings presumed non-HCBS but evidence may be presented to CMS for heightened scrutiny review. The State considers settings located in a building that also provides inpatient institutional treatment, any setting on the grounds of or adjacent to a public institution, or settings that isolate participants from the broader community, such as multiple locations on the same street operated by the same provider (including duplexes and multiplexes) to be not yet compliant, but evidence may be presented to CMS for heightened scrutiny review when the State further evaluates and determines that the setting does meet the qualities for home and community based settings. Approximately 34 settings (physical addresses) through DHSS may fall under this category; and

• No – Settings that do not and cannot meet HCBS characteristics. The state considers settings located in Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) (except Respite), Nursing Facilities/Skilled Nursing Facilities, Hospitals and Institutions for Mental Disease (IMD) to not be compliant.

Heightened Scrutiny Evaluation of HCBS Service Settings and Addresses

MHD worked with DHSS to develop agency processes to identify HCBS Settings and Addresses for Heightened Scrutiny based on the CMS Heightened Scrutiny process:
https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/settings-that-isolate.pdf
The agency processes will help the State to determine whether such settings in fact should be "presumed to have the qualities of an institution," and if so, will require submission of evidence to CMS in order to demonstrate that the setting does not have the qualities of an institution and that is does have the qualities of a home and community-based setting. The State will review data pertaining to:
• services utilized by individuals receiving services in the setting;
• amount of time spent in such setting;
• on-site visits and assessments of physical location and practices;
• review of the person-centered plans;
• interviews with individuals to understand their experiences when receiving services in the settings;
• review of providers policies, trainings, and other applicable service related documents;
• and a review of the provider's proposed transition plan, including the timeline and impact of the proposed changes.

The State does not intend to submit to CMS for application of Heightened Scrutiny unless the State believes that the setting in fact has the qualities of a home and community based setting, which may include steps that will be taken by the provider as part of an approved transition plan with providers to review specified settings for compliance with the HCBS Settings Rule using the process defined by CMS. The State will engage stakeholders, advocacy organizations, and providers in the review process. The state will further evaluate and continue to work with providers on any setting that may be institutional in nature

– by virtue of physical location, or because it is designed specifically for people with disabilities and individuals in the setting are primarily or exclusively people with disabilities and the on-site staff that provide services to them. Per CMS, evidence of how a setting overcomes its presumed institutional qualities should focus on the qualities of the setting and how it is integrated in and supports full access of individuals receiving HCBS into the greater community.

o DHSS gathered information through licensure records to determine which Adult Day Care (ADC) settings were located on the grounds of or adjacent to an institutional setting. DHSS identified seven Adult Day Care Centers located on the grounds of or adjacent to an institutional setting. Upon further clarification and guidance from CMS, DHSS reexamined the Heightened Scrutiny information gathering process. Utilizing the GIS system that DMH used in cooperation with MHD and the state's Office of Administration, DHSS was able to identify ADCs that were unidentified in the previous information gathering process. Beginning October 16, 2014, the State developed a GIS system that layers provider and participant addresses across all agencies. Provider types include HCBS waiver providers such as residential, day services, adult day care, aged and disabled, and employment. It also includes hospitals, nursing homes, and state operated institutions. Service Setting addresses included in this mapping are DHSS sites licensed or certified by the department's Regulation and Licensure Unit, Department of Health and Senior Services Nursing facilities, public institutions, Residential Care Facilities, Assisted Living Facilities The GIS system was completed by March 30, 2015.

o DHSS will use GIS to analyze locations of individuals' service settings (co-located and operationally related within 1/8 mile) and settings that provide individuals multiple HCB services in one location and address to identify potential settings that isolate or are institutional in nature.
o DHSS has identified approximately 34 settings that appear to have one or more qualities requiring further review.
• The 34 providers requiring further review are first subject to a Heightened Scrutiny Review by MMAC:
o MMAC will review the 34 providers, ensuring the settings have overcome the presumption of having institutional qualities, yet still fall into one of the "three prongs" for settings presumed not HCBS.
o MMAC will contact those providers to educate them about the Heightened Scrutiny process.
o MMAC will collect and coordinate any participant information provided to them by DHSS.
o MMAC will determine if any of the settings reviewed under any of the three prongs should be elevated to Heightened Scrutiny to CMS, along with an evidentiary package, for review, based upon the following criterion: Did MMAC determine after its review that the provider does not fit any of the three prongs? If the provider still falls under one or more of the three prongs, it will be elevated to CMS for heightened scrutiny review.

• MMAC Heightened Scrutiny Review process will include:

o Determining if the setting is integrated in the community to the extent that the persons without disabilities in the same community would consider it a part of their community and not associate the setting with the provision of services to person with disabilities.
o Determining if individuals participate regularly in typical community life activities outside the setting to the extent the individuals' desire.
o Determining if the setting is co-located with other settings and operationally related to those other settings (owned and operated by the same provider) in such a fashion that individuals' ability to interact with the broader community is limited.
o Determining if the services provided to the individuals, and the activities in which the individuals participate, are engaged with the broader community.
o MMAC will review data to which it has access regarding the billing for and provision of services and compare this to any information otherwise available regarding the setting as a whole.
o MMAC will conduct a follow up site visit and further assess, in person, the physical location and practices.
o MMAC will receive and coordinate any follow up interviews with participants conducted by DHSS, and any follow up review of participant person-centered care plans conducted by DHSS.
o MMAC will work closely with the provider(s) and their individual transition plan(s) every six months or more frequently if necessary.
• Heightened Scrutiny Review:
• MMAC will submit evidence to CMS regarding the identified providers who "passed" internal scrutiny review and why, and why they are not being referred for heightened scrutiny review
• For those providers who do need to be elevated to CMS for heightened scrutiny review, MMAC will submit types of evidence to CMS to demonstrate that the setting(s) does not isolate individuals receiving HCBS from the broader community of individuals not receiving HCBS, and
• MMAC believes the setting can be brought into full compliance by March 2019; and
• MMAC has demonstrated that persons receiving services are not isolated from the greater community of persons not receiving HCBS
• MMAC has demonstrated that there is strong evidence the setting does not meet the criteria for a setting that has the qualities of an institution.

• MMAC's rationale shall focus on qualities of the setting and how it is integrated in and supports full access of individuals receiving HCBS into the greater community, and strategies the setting has implemented to rectify and fully overcome its former institutional qualities or characteristics that isolate participants. MMAC's rationale shall not focus on the aspects and/or severity of the disabilities of the individuals served in the setting, or why isolating or institutional qualities or characteristics are justified.
• MMAC's rationale may include observations from on-site review(s), licensure requirements or other state regulations, proximity to/scope of interactions with community settings, provider qualifications for HCBS staff, documentation in the person-centered care plan that the individuals' preferences and interests are being met, evidence that that individuals chose their setting, and details of proximity to public transport or other transportation strategies to facilitate integration, and pictures of the site and any other demonstrable evidence. Site visits should focus on the individuals' experiences and the presence or absence of qualities of home and community based settings.
• MMAC will include the full name, location and evidentiary package of each setting to be submitted for CMS review so that public comment information may be added prior to inclusion in the STP and prior to submission to CMS for heightened scrutiny review.
• MMAC will respond accordingly with the provider(s) following CMS response. If the setting does not comply, providers will be afforded the opportunities outlined by CMS, to include implementing necessary modifications by the end of the transition period, furnishing Medicaid services that do not require their provision in an HCB setting, or being recognized as an institution.
• Heightened Scrutiny addresses and evidence packages will be posted for public comment and shared with CMS. Per CMS, evidence of how a setting overcomes its presumed institutional qualities should focus on the qualities of the setting and how it is integrated in and supports full access of individuals receiving HCBS into the greater community.

Initial Settings Assessment Tool Development

MHD required the operating agencies to develop an initial assessment tool to be used by designated state staff for the initial on-site assessments. DHSS was required to begin this process on February 1, 2014 and complete it by December 15, 2014.
o MMAC's Assessment Tool was based on CMS exploratory questions as related to the specific requirements under the regulation. MMAC's initial settings assessment tool is titled "Home and Community Based Setting Survey". The tool will be used during the initial on-site survey of all Adult Day Care Centers. The MMAC tool may be found at http://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/

o MMAC personnel designed and received in-house training regarding the tool and how to utilize it during on-site visits.

Initial On-Site Assessment

Assessments began on December 16, 2014 and were completed by April 1, 2016.

o MMAC completed on-site visits of all 112 Adult Day Care providers by April 1, 2016. 100% of these providers were contacted in person (the on-site visit) due to the small number.
o MMAC reviewed all the completed assessments (surveys) done on-site and prepared a report of the findings.
o The report was posted to the MMAC website.
o Participant surveys results were reviewed based on provider information and will be attached to the provider surveys, and a second review conducted to determine consistencies/inconsistencies and identify any issues that require further review.
o MMAC will create an addendum to the report. This addendum will incorporate the second review conducted.
o MMAC will provide results to 100% of the Adult Day Care providers via US Mail, including a self-addressed, postage-paid return envelope. Providers will be requested to submit feedback regarding areas of non-compliance, including individual transition plans that explain how the provider will become compliant
o Provider responses will be maintained, tracked, and compiled by MMAC.
o MMAC will assist providers that request assistance in their efforts to become compliant. MMAC has a team of personnel who work exclusively with HCBS providers, as well as three enrollment personnel who work exclusively with enrolling HCBS providers. Provider responses will be reviewed and addressed on a semi-annual basis. This will allow the state ample time to assist providers with any necessary compliance efforts/remediation needs by 2019.

Assessments Results Report

The state will compile and analyze findings of initial assessments and surveys by December 31, 2016. Findings will be presented to CMS, state leadership and stakeholders. Additionally, DHSS will compile and analyze participant survey results by Adult Day Care and in the aggregate. Based on these findings, the state will follow-up as appropriate. DHSS will provide results of the participant surveys to MMAC.

Provider Enrollment Process Assessment

MHD required DHSS to operationalize mechanisms to incorporate assessment of settings into existing processes for provider enrollment. This process began on November 14, 2014 and was implemented on March 2, 2015.
o MMAC posted information about the Final Rule and setting requirements on its website for all prospective and newly enrolling providers.
o All newly enrolling HCBS providers go through a contract/proposal process with MMAC before receiving a MHD participation agreement.
o MMAC personnel who handle the HCBS provider enrollment processes have received training regarding the Final Rule and setting requirements.
o MMAC has incorporated the setting requirements into its proposal process for HCBS providers. Specifically, all HCBS providers are given information and the self-assessment. Adult Day Care Waiver providers are surveyed by MMAC personnel during the pre-enrollment on-site visit.

Remediation Strategies

The State proposes a remediation process that will capitalize on existing HCBS Waiver quality assurance processes including provider identification of remediation strategies for each identified issue, and on-going review of remediation status and compliance. The state may also prescribe certain requirements to become compliant. The State will also provide guidance and technical assistance to providers to assist in the assessment and remediation process. Providers that fail to remediate non-compliant settings timely may be subject to sanctions in accordance with 13 CSR 70-3.030.

Missouri Code of State Regulation (CSR) Filing

The State will file changes to administrative rules as needed to reflect federal regulations on HCBS settings. The rulemaking process is lengthy, entailing a minimum of approximately nine months from the notice of rulemaking to a final rule. The State will begin filing changes to reflect the Home and Community Based Final Rule on March 1, 2015 and will complete the filing by January 1, 2017. The final file date will be dependent upon approval of the Governor's Office.
o As a result of the assessment, DHSS found state standards compliant, partially compliant or non-compliant with the HCBS Rule. Adult Day Care Licensure 19 CSR 30-90, In-Home Service Standards 19 CSR 15-7, Personal Care Rule 13 CSR 70-91, Consumer Directed Services 19 CSR 15-8 will come into compliance upon the adoption and implementation of an overarching HCBS Waiver Administration rule that details the CMS HCBS settings characteristics required for all 1915c waiver settings. The State will add the new chapter to 13 CSR 70 entitled Home and Community Based Services (HCBS) Waivers. This rule implements federal regulatory requirements promulgated by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services at 42 CFR 441.301(c)(4) establishing the requirements that must be met for settings in which home and community based services are provided under a 1915(c) HCBS Waiver Program. A Public Comment period of 30 days will be held. Comments are submitted to the agency proposing the rule or rule changes. The agency will prepare a final order of rulemaking that includes summaries of all the comments received, the agency responds to each comment, and any changes made to the proposed rule as result of the comments. The final rule must be filed with the Secretary of State no later than ninety days from the date for filing public comment, or within ninety days after a hearing if a hearing is held on the proposed rulemaking. The new rule change becomes effective thirty days after the final order of rulemaking is published in the Code of State Regulations. Amendments needed to specific manuals are referenced in the remediation column of the crosswalk and language will be added upon CSR implementation.

Direct conflicts in the areas of individual initiative, respect and independence in making life choices, and freedom from coercion and restraint were identified in the Child and Adult Care Food Program manual, which affects participants receiving services through the Adult Day Care Waiver and Aged and Disabled Waiver, adult day care setting. These state guidelines are based directly on federal regulations (7 CFR 226.20) for the program. DHSS will continue to work with partners to address these inconsistencies.

Provider Manuals, Policies, and Procedures Revisions

MHD and DHSS will revise HCBS provider manuals, policies, and procedures to incorporate HCBS final rule requirements. The revisions will clarify expectations of participants' control of their environment and access to the community. Revisions to the provider manuals, policies, and procedures began on January 1, 2015 and will be completed by July 1, 2017.
o DHSS Waiver program manuals and polices were either silent or partially compliant and are in the process of revision to incorporate all components of the HCBS settings rule. The Child and Adult Care Food Manual is in conflict with the HCBS settings rule and DHSS will continue to work with partners to address these inconsistencies.
o Proposed changes for DHSS waivers will be included in each waiver renewal application.

Incorporate Education and HCBS Waiver Compliance Understanding into Provider Enrollment
MHD requires DHSS, and MMAC to educate providers on the HCBS Final rule, and to incorporate education into the Provider Enrollment process. Operating agencies will use resources and tools such as the Missouri Exploratory Questions for Assessment of HCBS Residential Waiver Settings, Missouri – Settings with the Potential Effect of Isolating Individuals from the Broader Community. The requirements of the Home and Community-Based Federal rule will be incorporated into Provider Enrollment Tools and the Provider Agreements. This process began on August 17, 2015 and will continue with all new providers enrolling on an on-going basis.
The State will evaluate through the heightened scrutiny process any new settings for enrollment that have an institutional or isolating quality while presenting deadlines for enrolled providers to come into compliance. Specific processes are outlined below.
o MMAC has posted information regarding the Final Rule and setting requirements on its website for all prospective and newly enrolling providers.
o Newly enrolling HCBS providers will be provided information on HCBS setting requirements as part of their enrollment materials.
o MMAC personnel will educate all HCBS providers about the Final Rule and setting requirements during pre-enrollment on-site visits. Adult Day Care providers will be surveyed during the pre-enrollment on-site visit.
o MMAC will provide information to HCBS providers during Annual Provider Update Meetings held semiannually, Designated Manager Trainings held quarterly, and at other workshops, board meetings, seminars, and conferences.
o MMAC will monitor and verify setting compliance for all Adult Day Care Providers at each revalidation. Revalidation occurs at least every five years, and requires an on-site visit to the facility.
o MMAC will monitor and verify setting compliance during on-site audits of Adult Day Care providers. MMAC audits all HCBS providers every three years if not more often.
o MMAC will monitor and verify setting compliance on an ad-hoc, more frequent basis when on-site for other reasons such as an investigation of the provider.

Provider Update Meetings and Trainings

MHD requires MMAC to educate providers on the HCBS Final rule during the Provider Enrollment process. Operating agencies will use resources and tools such as the Missouri Exploratory Questions for Assessment of HCBS Residential Waiver Settings, Missouri – Settings with the Potential Effect of Isolating Individuals from the Broader Community. This education began on June 23, 2014 and will continue ongoing thereafter. The requirements of the Home and Community-Based Federal rule will be incorporated into Provider Enrollment Tools and the Provider Agreements. Specific processes are outlined below.
o MMAC will provide information to HCBS providers during Annual Provider Update Meetings and Provider Designated Manager Trainings, hosted by MMAC.
o MMAC will provide information to HCBS providers during MHD workshops.
o MMAC will provide information to HCBS providers during HCBS association meetings and conferences.

HCBS Waiver Settings Assessment Findings and Provider Individual Remediation

MMAC posted aggregate initial on-site assessment results on the MMAC website (http://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/). DHSS will provide MMAC with the results of the participant surveys. MMAC will utilize those results by matching any participant surveys that identify the provider, with the provider surveys. MMAC will then conduct a second review to determine consistencies/inconsistencies and will prepare an addendum to the report, which will be posted to the website, as well.

MMAC will present providers with results via US Mail, including a self-addressed, postage-paid envelope. MMAC will request providers submit feedback to the results, including individual transition plans that address any area(s) of noncompliance. These results or "summary of findings" (including requests for individual transition plans) will be distributed to service providers by August 1, 2016. These plans will provide details about the steps to be taken to remediate issues and the expected timelines for compliance. This timeline, with milestones, will ensure providers have ample time to reach compliance. MMAC personnel will provide assistance to any provider that requests it, regarding how to achieve compliance.

The review of individual transition plans will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. MMAC will allow reasonable timeframes for large infrastructure changes. MMAC will track responses with dedicated follow up on a semi-annual basis. This will be done for 100% of Adult Day Care providers.

Providers that become compliant are still subject to a review to verify their compliance. Providers that do not appear to have

become compliant, or when there is reason to believe they are not compliant are subject to a review and will also be notified of future consequences (provider sanctions).

If a provider fails to become compliant, sanctions may be imposed according to 13 CSR 70-3.030.

MMAC Response to Provider Individual Transition Plans

MMAC will receive the individual transition plans. MMAC personnel will track receipt of the plans, conduct an initial review, and continue to review in a semi-annual fashion.

MMAC will provide feedback to providers after the initial reviews and after subsequent reviews. Subsequent reviews will be completed as providers achieve milestones, after they submit updates or changes to their transition plans, and every six months as part of MMAC's semiannual review.

MMAC's feedback will inform providers if it appears (a) they have become wholly compliant; (b) if they are making progress toward compliance; or (c) if it appears they are not making progress toward compliance. MMAC will give the providers details regarding what steps they must take to achieve compliance and provide assistance if requested. Progress toward compliance will be indicated by the individual transition plans sufficiency and by the providers making actual changes based upon their plans.

As MMAC audits all HCBS providers every three years, all providers who submit individual transition plans are subject to a review, regardless of whether or not they appear to be compliant, making progress toward compliance, or if they appear to be non-compliant. Compliance to the Final Rule and setting requirements will be incorporated into MMAC's audit tool. Therefore, MMAC will review the providers' adherence to their plans by the level necessitated by the scope of apparent noncompliance. MMAC may visit the provider solely for the purpose of plan adherence, may conduct an audit, or may open an investigation.

Providers that do not become compliant, or when there is reason to believe they are not compliant, will be notified of provider sanctions according to 13 CSR 70-3.030.

MMAC's response to individual provider transition plans will occur between March 2, 2015 and March 17, 2018.

Periodic Provider Remediation Status Updates

Providers will submit semiannual status updates based on each aspect of the individual transition plans. MMAC will follow a process of semiannual review. Technical assistance will be provided if there is a problem with the implementation of the individual transition plans, such as providers failing to properly implement the plans, providers changing the plans, or changing implementation strategies. Status updates will occur between March 2, 2015 and March 17, 2018.

Assessment Results Report – State Level Remediation

After findings from settings assessments and provider and individual surveys have been presented to CMS, State leadership and stakeholders, the State will work with stakeholders to develop remediation strategies for any necessary systems processes changes. This process will occur between March 2, 2015 and March 17, 2018.
Ongoing Compliance/Monitoring Reviews

MMAC will conduct ongoing reviews of enrolled Adult Day Care providers to establish and monitor levels of compliance. MMAC will incorporate settings requirement information into its pre-enrollment and revalidation site visits of all HCBS providers, and survey the Adult Day Care providers during these visits. MMAC will also provide information about the setting requirements during on-site audits and investigations of HCBS providers.
Ongoing reviews include the following:
• On-site surveys completed during provider revalidation, to occur no less than every five years.
• On-site surveys completed during provider audits, which occur every three years.
• Provider assessments will be used as a training tool during Annual Provider Update Training. This training is held twice a year, and providers attend either the spring session or the fall session
• Provider assessments will be used as a training tool at annual provider association conferences
• MMAC personnel will perform reviews of individual provider transition plans. These reviews will be completed upon receipt, and in a dedicated fashion semiannually. The reviews may be completed more often in cases of provider milestones, or plan changes.
• Ongoing assessment will also occur on an ad hoc basis due to provider investigations, meetings, formal requests for

education, and informal communications.
• Reviews may also be conducted when there is reason to believe a provider previously found to be non-compliant has not improved.
• When providers previously found to be non-compliant have improved, spot-checks may still be conducted outside of scheduled audits, investigations, or revalidation efforts, solely for the purpose of checking ongoing compliance levels.

DHSS will continue to reassess HCBS participants, including those receiving the Adult Day Care service. All participants authorized for HCBS shall have a reassessment completed within 365 days of the last level of care determination. For participants receiving an Adult Day Care service, DHSS or its designee shall perform face-to-face reassessments with the participant utilizing the InterRAI HC and the HCBS Care Plan and Participant Choice Statement (DA-3) to establish continued eligibility of services and compliance with the HCBS Settings Rule. Any concerns with specific settings shall be reported to MMAC.

The process began on April 2, 2016 and will continue on an on-going basis.

Provider Sanctions

In accordance with 19 CSR 30-90, MMAC will sanction providers that have failed to meet remediation standards and have failed to cooperate with the HCBS Settings Transition.

Individuals Transition to Settings that Align with HCBS Requirements

If relocation of individuals is necessary, the local DHSS Adult Protective and Community staff will work with individuals through phone contact and face-to-face visits to ensure they are transitioned to settings meeting HCBS Setting requirements. Individuals will be given timely notice, and will have a choice of alternative settings through a person-centered planning process. Transition of individuals will be comprehensively tracked to ensure successful placement and continuity of Waiver service. DHSS estimates less than 450 participants may need to be relocated to HCBS compliant settings.

This milestone will begin March 16, 2015 and continue ongoing on an individual provider basis.

Public Comment

The State proposed to collect public comments on the transition plan in-person during two public forums. The State also offered a conference line during the public forums and provided an address for the public to mail in comments. In addition to posting the transition plan and related materials on the MO HealthNet website, stakeholders were contacted directly and provided with transition plan documents and information on the stakeholder forums. Stakeholders contacted include the Missouri Adult Day Care Association and Leading Age Missouri.

Announcement of Public Comment Period

The State released a Summary document, the Draft Transition Plan, and Draft Settings Analysis on the state website. A newspaper notice and an email blast were released on December 30, 2014, and the stakeholders were contacted directly to inform them of the opportunity to provide public comment. This began on December 29, 2014 and was completed on March 7, 2015. The notice included the draft transition plan, the draft settings analysis, and the HCBS Settings Summary Document.

Public Comment Period and Meetings - Proposed Transition Plan
The State commenced stakeholder forums, shared the proposed transition plan with the public, collected comments, developed state responses to public comments, and incorporated appropriate suggestions into the transition plan. The State will continue to document all iterations of the transition plan. The Response to Public Comments document is included in the Transition Plan. This began on December 29, 2014 and was completed on March 7, 2015.

Announcement of Public Comment Period – Amended Transition Plan
The State released the Draft Amended Statewide Transition Plan on the state website. A newspaper announcement and an email blast were released and stakeholders were contacted directly to inform them of the opportunity to provide public comment. This began on July 29, 2016 and was completed on September 30, 2016.

Public Comment Period and Meetings - Amended Transition Plan
This amended Statewide Transition Plan builds on the originally proposed Statewide Transition Plan submitted on March 14, 2015. This plan includes data gathered from the provider and participant self-assessments, information submitted in response

to the CMS Letter of Reaction, as well as further details in response to conference calls held with CMS on September 15, 2015 and March 17, 2016 regarding settings and assessment validation. This Amended Transition Plan also reflects guidance that continues to be issued by CMS, including but not limited to the Settings Requirements Compliance Toolkit and the HCBS Training Series Webinars Presented During SOTA Calls (Home and Community-Based Settings, Excluded Settings, and the Heightened Scrutiny Process – November, 2015; and Home and Community-Based Setting Requirements: Systemic and Site-Specific Assessments and Remediation – December, 2015).

The State shared the proposed transition plan with public, collected comments, developed state responses to public comments, and incorporated appropriate suggestions into the transition plan. The State will continue to document all iterations of the transition plan. The Response to Public Comments document is included in the Transition Plan. This began on July 29, 2016 and was completed on September 30, 2016.

Public Comment Retention

The State will safely store public comments and state responses for CMS and public consumption. This began on December 29, 2014 and will be completed on March 17, 2019.

Posting of Transition Plan Iterations

The State will post each approved iteration of the transition plan to its website. This began on December 29, 2014 and will be completed on March 17, 2019.

The state will include the Transition Plan and the rationale for the changes made.

Assessment Findings Report

The State posts the summary of findings of the initial on-site assessments and remediation strategies annually by August 1. This will begin on July 1, 2016 and will be completed on January 1, 2017. The State will include the data compiled and the remediation strategies at an aggregate level.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   - **The waiver is operated by the State Medicaid agency.**

     Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

     - **The Medical Assistance Unit.**

       Specify the unit name:

       (Do not complete item A-2)

     - **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:
Missouri Department of Health and Senior Services, Division of Senior and Disability Services

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   The HCBS waiver quality management strategy specified throughout the waiver is used to ensure that the operating agency, the Department of Health and Senior Services (DHSS), is performing the delegated waiver operational and administrative functions in accordance with the waiver requirements during the period the waiver is in effect. MHD and DHSS meet quarterly to discuss administrative/operational components of the waiver. This time is also used to discuss the quality assurances strategy specified throughout the waiver application. A Memorandum of Understanding exists between the two agencies, and communication remains open and additional discussions occur on an ongoing and as needed basis.

   MHD reviews reports submitted no less than annually by DHSS/DSDS to ensure that the operational functions as outlined in A-7 as well as throughout the waiver are being implemented as specified in the waiver application. MHD and DHSS work together to address any deficiencies, outlining the steps to be taken to ensure the waiver assurances are being met. MHD works closely with DHSS to set goals and establish timeframes for remediation and improvement activities. If significant problems are identified in the DHSS/DSDS reporting process, MHD may decide to follow-up with a targeted review to ensure the problem is remediated. In general though, remediation of identified problems will be validated through the reports produced by DHSS or MHD. The Medicaid agency oversight is maintained by providing that the operating agency track and no less than annually report to the Medicaid agency performance in conducting the operational functions of the waiver, thus eliminating the need in most cases for redundant record reviews and duplication of efforts for the two state agencies.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
   - ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
     Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   - ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):
   - ◉ **Not applicable**
   - ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
     - ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

       Specify the nature of these agencies and complete items A-5 and A-6:
     - ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

       Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	☑	☑
Waiver enrollment managed against approved limits	☑	☑
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑
Qualified provider enrollment	☑	☐
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☑
Rules, policies, procedures and information development governing the waiver program	☑	☑
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
   i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures

found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver service units billed that were delivered based on authorized units of service. Numerator = Total number of waiver service units billed by service procedure code. Denominator = Total number of waiver services authorized by service procedure code.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of policies, procedures and rules reviewed by MHD, applicable to the waiver. Numerator = Number of policies, procedures and rules reviewed by MHD, applicable to the waiver. Denominator = Total number of policies, procedures and rules released by the operating agency.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MHD Policy Tracking

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of documented findings from DHSS and MHD case reviews which have been remediated. Numerator = Total number of documented findings from DHSS and MHD case reviews which have been remediated. Denominator = Total number of documented findings.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of the total dollars for services paid not to exceed total approved waiver expenditures. Numerator = Total dollars for services paid not to exceed total approved waiver expenditures. Denominator = Total approved waiver expenditures.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Issues which require individual remediation may come to MO HealthNet Division's (MHD) attention through

review of Division of Senior and Disability Services (DSDS) reports, as well as through day-to-day activities of MHD, e.g., review/approval of provider agreements, utilization review and quality review processes, complaints from MO HealthNet participants related to waiver participation/operation by phone or letter, etc. MHD addresses individual problems related to delegated functions as they are discovered by contacting DSDS and advising them of the problem. A follow-up memo or email is sent from MHD to DSDS identifying the problem and if appropriate a corrective action resolution. While some issues may need to be addressed immediately DSDS is required to provide a written response to MHD that specifically addressed the problem identified by MHD. Written documentation will be maintained by both MHD and DSDS and as needed discussions will be included at the quarterly meeting. Any trends or patterns will be discussed and resolved as appropriate. Individual problems that are part of the report process will be included in the appropriate reports.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					

	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	63	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The State further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Physically disabled participants reaching the age of 65 remain eligible for services through the Aged and Disabled Waiver as a result of the "Aged" category.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [ ] **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- [ ] **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	26932
Year 2	26932
Year 3	26932
Year 4	26932
Year 5	26932

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number

of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

It is the states intent to have adequate slots to allow all eligible participants to enroll in the waiver.

Individuals are enrolled based upon the individual meeting the nursing facility (NF) level of care (LOC) and criteria specified in this waiver. In the event all slots are filled during a waiver year, individuals will be enrolled based upon their NF LOC as determined in the InterRAI HC. If individuals have the same score, the date of referral will be used. The InterRAI HC is a standardized assessment tool used to determine the NF LOC; with the higher points representing individuals who have the greatest need.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ○ **SSI Criteria State**
   - ◉ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ○ **No**
   - ◉ **Yes**

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☐ **SSI recipients**
- ☑ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☑ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ○ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage: [ ]

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in**

§1902(a)(10)(A)(ii)(XIII)) of the Act)

- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Elect to serve all other mandatory and optional groups covered in State Plan.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- (•) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- [x] **A special income level equal to:**

Select one:

- ( ) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- (•) **A dollar amount which is lower than 300%.**

Specify dollar amount: 1285

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ○ **100% of FPL**
- ○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

- ☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

For each subsequent year, for the duration of this waiver period, the income cap will be increased by a percentage equal to the Social Security cost of living adjustment. These changes will be effective January of the applicable year.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- ☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

- ◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - ○ **Use spousal post-eligibility rules under §1924 of the Act.** *(Complete Item B-5-c (209b State) and Item B-5-d)*
  - ◉ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)** *(Complete Item B-5-c (209b State). Do not complete Item B-5-d)*
- ○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.** *(Complete Item B-5-c (209b State). Do not complete Item B-5-d)*

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ **The following standard included under the State plan**

  (*select one*):

  - ○ **The following standard under 42 CFR §435.121**

    Specify:

    [ ]

  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify percentage: [ ]

    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]

  - ○ **A percentage of the Federal poverty level**

    Specify percentage: [ ]

  - ○ **Other standard included under the State Plan**

    Specify:

- ○ **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:**

  Specify:
- ● **Other**

  Specify:

  The allowance for the needs of the participant is $1,285 as of 1/1/17. For each calendar year for the remainder of this waiver period, allowance for the needs of the participant will be adjusted on January 1 by a percentage equal to any Social Security COLA in effect for that year.

ii. Allowance for the spouse only (*select one*):

- ○ **Not Applicable (see instructions)**
- ● **The following standard under 42 CFR §435.121**

  Specify:

  The Federal Benefit Rate.
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- ○ **Not Applicable (see instructions)**
- ● **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

Specify:

Other
Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
The State does not establish reasonable limits.
The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- **The following standard included under the State plan**

  (*select one*):

  - **The following standard under 42 CFR §435.121**

    Specify:

    [ ]

  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The special income level for institutionalized persons**

    (*select one*):

    - **300% of the SSI Federal Benefit Rate (FBR)**
    - **A percentage of the FBR, which is less than 300%**

      Specify percentage: [ ]

    - **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]

  - **A percentage of the Federal poverty level**

    Specify percentage: [ ]

  - **Other standard included under the State Plan**

    Specify:

    [ ]

- **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

The allowance for the needs of the participant is $1,285 as of 1/1/17. For each calendar year for the remainder of this waiver period, allowance for the needs of the participant will be adjusted on January 1 by a percentage equal to any Social Security COLA in effect for that year.

ii. Allowance for the spouse only (*select one*):

Not Applicable (see instructions)

The following standard under 42 CFR §435.121

Specify:

Optional State supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other
Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
The State does not establish reasonable limits.
The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):
SSI standard
Optional State supplement standard
Medically needy income standard
The special income level for institutionalized persons
A percentage of the Federal poverty level

Specify percentage:
The following dollar amount:

Specify dollar amount: [ ] If this amount changes, this item will be revised

○ **The following formula is used to determine the needs allowance:**

Specify formula:

◉ **Other**

Specify:

The allowance for the needs of the participant is $1,285 as of 1/1/17. For each calendar year for the remainder of this waiver period, allowance for the needs of the participant will be adjusted on January 1 by a percentage equal to any Social Security COLA in effect for that year.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The State does not establish reasonable limits.**

○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the

provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Division of Senior and Disability Services (DSDS) staff, at a minimum, meet the following experience and educational requirements. One or more years of experience as an Adult Protective and Community Worker (APCW) I, Social Service Worker (SSW) I, or Children's Service Worker (CSW) I with the Missouri Uniform Classification and Pay System; or an undergraduate degree from an accredited college or university in Social Work, Psychology, Sociology, Gerontology, Nursing, Health Science, Health Care Administration, Human Resources, Political Science, Anthropology, Human Services, Public Administration, Education, Counseling, Criminal Justice, or closely related field.

Position definition of those performing the initial evaluations are as followed:

Adult Protective and Community Worker I(formerly SSW I): This is entry-level professional social service work in the Department of Health and Senior Services (DHSS) providing protective services and/or coordinating in-home services on behalf of senior and/or disabled adults.

Children’s Service Worker I(formerly SSW I): This is entry-level professional social service work in the Children's Division of the Department of Social Services providing protective services on behalf of children and families in instances of abuse, neglect, or exploitation.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an

individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

In order to be eligible for entry to the Aged and Disabled Waiver, individuals must meet nursing facility level of care (LOC) as specified in the Code of State Regulation (CSR) at 19 CSR 30-81.030. Points are assigned based on the amount and degree of assistance needed by the individual and the complexity of the care needed (or the frequency of physician's ordered care) in nine categories that explore areas of daily living. The categories are: (1) Monitoring: the amount of medical oversight needed to remain independent. (2) Medications: the ability to administer medicine and complexity of the drug regime. (3) Treatments: physician ordered medical procedure(s) intended to treat a specific medical condition. (4) Restorative: teaching and/or training activities designed to maintain or restore a person to a higher level of functioning. (5) Rehabilitative: physician ordered rehabilitation therapy (speech, occupational, physical) - points are based on frequency of services. (6) Personal Care: bowel or bladder problems or the ability to bathe, shampoo, etc. (7) Dietary: the degree of specialized diet or the ability to prepare and eat meals. (8) Mobility: the ability to move from place to place. (9) Behavior: any problems associated with orientation, memory recall, and judgment.
Scoring Methodology: any combination of points which meets the LOC specified in 19 CSR 30-81.030 qualifies an individual to receive Aged and Disabled Waiver services. Based on the criteria established in each category, points are assigned in each of the nine categories in three point increments: 0 points: assigned if the individual requires no assistance, is independent, does not have the treatment/therapy/problem, etc. 3 points: assigned if problems are identified: personal oversight or management is required; minimum numbers of treatments/therapies/medications are ordered. 6 points: assigned if problems are moderate; daily or regular assistance is required; moderate frequency of treatments/therapies ordered by a physician. 9 points: assigned when physical or medical problems require maximum assistance or complexity of the drug regime.

Waiver applicants are initially evaluated for waiver services through the use of a prescreen process. Potential waiver participants will be screened based on the nine LOC categories outlined in B-6-d. Participant information gathered during the prescreen process will be data entered into the HCBS Web Tool, a web-based system with behind the scenes LOC calculations to determine if the individual meets the criteria for LOC eligibility. Once LOC eligibility is initially determined, a home visit will be scheduled to complete the InterRAI HC. The InterRAI HC will confirm or deny the prescreen LOC determination through the use of behind the scenes decision tree algorithms based on the nine categories outlined in B-6-d. Reevaluations of LOC will utilize the InterRAI HC with the same algorithms determining continued LOC eligibility utilizing the same nine categories in B-6-d.

The InterRAI HC has been designed to be a user-friendly, reliable person-centered assessment system that informs and guides comprehensive care and service planning in community-based settings around the world. It focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences. When used on multiple occasions, it provides the basis for an outcome-based assessment of the person’s response to care or services. The interRAI HC can be used to assess persons with chronic needs for care, as well as with post-acute care needs (e.g., after hospitalization or in a hospital at home situation). The interRAI HC has been designed to be compatible with the suite of interRAI assessment and problem identification tools. Such compatibility advances continuity of care through a seamless assessment system across multiple health care settings, and promotes a person-centered evaluation rather than fragmented site-specific assessments.

The Home Care assessment system, or HC, was developed to provide a common language for assessing the health status and care needs of frail elderly and disabled individuals living in the community. The system was designed to be compatible with the Long Term Care Facility system that was implemented in US nursing homes in 1990-91.

Target Population
The HC was developed for use with adults in home and community-based settings. The instrument is generally used with the frail elderly or persons with disabilities who may or may not be receiving formal health care or supportive services.
The HC was designed to highlight issues related to functioning and quality of life for community-residing individuals. Information is gathered in the following domains:
• Identification Information
• Intake and Initial History
• Cognition
• Communication and Vision

- Mood and Behavior
- Psychosocial Well-Being
- Functional Status
- Continence
- Disease Diagnoses
- Health Condition
- Oral and Nutritional Status
- Skin Condition
- Medications
- Treatment and Procedures
- Responsibility
- Social Supports
- Environmental Assessment
- Discharge Potential and Overall Status
- Discharge
- Assessment Information

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The difference (other than lay-out/format) between the level of care (LOC) determination tools utilized for determining eligibility for nursing facility admission and waiver services is additional information is obtained to assist in service plan development. Both tools use the same scoring methodology described in Appendix B-6-d. The nine categories and scoring methodology are established in the state nursing facility regulation. As both tools utilize the same categories and scoring methodology based on the same state regulation, the outcomes from the DSDS LOC instruments are reliable, valid, and fully comparable to the nursing facility LOC instrument.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

An interview is scheduled with a potential waiver participant by a qualified individual as specified in B-6-c. Initial evaluations are conducted face-to-face, usually at the participant's residence, and reevaluations are usually conducted face-to-face but may be performed by phone by Division of Senior and Disability Services (DSDS) staff. Sufficient information is obtained during this interview to complete the Level of Care (LOC) evaluation utilizing the HCBS Web Tool as described in the administrative section of the application.
Potential waiver applicants will initially be evaluated for services through the use of a prescreen process. Potential waiver participants will be screened based on the nine LOC categories outlined in B-6-d. Participant information gathered during the prescreen process will be data entered into the HCBS Web Tool system and behind the scenes the LOC will be calculated to determine if the participant meets the criteria for LOC eligibility. Once LOC eligibility is initially determined, an interview will be scheduled to complete the InterRAI HC. The InterRAI HC will confirm or deny the prescreen LOC determination through the use of behind the scenes decision tree algorithms based on the nine categories outlined in B-6-d. Reevaluations of LOC will utilize the InterRAI HC with the same algorithms determining continued LOC eligibility utilizing the same nine categories in B-6-d.
The HCBS Web Tool requires LOC reassessments be completed within 365 days of the initial assessment or the last reassessment. Within the HCBS Web Tool the service plan and prior authorization are tied to a current assessment. This design will ensure that services are not reimbursed unless there is a current assessment.

In addition to the DSDS state staff, waiver providers may complete the InterRAI HC reassessment. The actual LOC determination will be made by the state, based on the information in the InterRAI HC. Designated DSDS Regional staff receive notification electronically 90 days prior to the date the reassessments are due to allow adequate time to schedule a reassessment with the participant to complete the InterRAI. Designated Regional DSDS staff will be responsible for assigning the reassessments and monitoring this report on a monthly basis to ensure all reassessments

are completed within 365 days of the last assessment. In addition DSDS Central Office staff will monitor reassessment reports to ensure they are completed within required timeframes. Should a backlog develop the state will address it through remediation based on the specific issue.

Should there be any overdue reassessments due to state staff, the error will be addressed and remediated on an individual basis. Participant services will not be impacted due to any state issue with reassessments. Overdue reassessments as a result of a participant being unavailable will be handled based on the individual situation of the participant (i.e., hospitalization; nursing facility; out of state visiting family, etc.). Services may not resume until the participant receives a reassessment. Waiver services for individuals who refuse a reassessment will be terminated and the participant will receive a fair hearing notice.

The provider's aides are required to report to their supervisor when the care needs of the participant changes. The providers, in turn, are required to report to DSDS anytime there is a change in the participant's needs. DSDS then has further discussion with the participant to discuss any potential care plan changes. Pursuant to state statute, at any time the provider owner, operator, or any employee is aware of, or suspects any abuse, neglect, or exploitation has occurred, the provider is required to immediately report that information to the Department of Health and Senior Services' Central Registry Unit (CRU) for further investigation. In addition, DSDS conducts, no less than annually, case record reviews on a statistically valid sample of waiver participants. This includes reviewing the care plan and all supporting documentation in that participant's case record.

Direct care staff must be at least eighteen (18) years of age; be able to read, write and follow directions; and have at least six (6) months paid work experience as an agency homemaker, nurse aide, maid or household worker - or - at least one (1) years' experience, paid or unpaid, in caring for children or for sick or aged individuals - or successful completion of formal training in nursing arts or as a nurse aide or home health aide. Twenty (20) hours of orientation training must be provided within the first 30 days of employment.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**

  Specify the qualifications:

  A Registered Nurse (RN) or an individual with the same qualifications as those established in Section B-6:c.

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

DSDS regional staff receive a report of participants, 90 days prior to the date the reassessments are due, to allow adequate time to schedule a reassessment with the participant to complete the InterRAI. Designated staff in the regions will be responsible for assigning the reassessments and monitoring this report on a monthly basis to ensure all reassessments are completed within 365 days of the last assessment. In addition, DSDS Central Office staff will monitor reassessment reports to ensure they are completed within required timeframes.

Any reassessment completed and submitted to the State by HCBS providers shall be reviewed by and approved by State staff.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of

care are maintained:

Per 42 CFR §441.303(c)(3), DSDS assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Records regarding the evaluation/reevaluation are maintained in the HCBS Web Tool system, a component of MO HealthNet Divisions' CyberAccess

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of initial LOC determinations that were completed prior to receipt of a waiver service. Numerator = Number of initial LOC determinations reviewed that were completed prior to receipt of a waiver service. Denominator= Number of LOC determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Cyber system and or MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample**

		Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participant records reviewed with an annual redetermination within 365 days of their last LOC evaluation. Numerator = Number of participant records reviewed with an annual redetermination within 365 days of their last LOC evaluation. Denominator = Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of initial LOC instruments that were applied appropriately as described in the approved waiver. Numerator = Number of initial LOC instruments that were applied appropriately as described in the approved waiver. Denominator = Number of LOC instruments reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

When an error is discovered during a Division of Senior and Disability Services (DSDS) case record review or one is identified in a DSDS report, a DSDS supervisor reviews the error, and works with the worker who completed the assessment to appropriately address the error. General methods of remediation may include: re-training staff, discussions during area and regional meetings and/or change in DSDS policy or procedure.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

At the initial evaluation qualified individuals as specified in B-6-c explain to the potential waiver participant the services available through the Aged and Disabled Waiver. Individuals can then make an informed choice between receiving services through a nursing facility or the Home and Community-Based Services, State Plan and/or waiver. The form that documents participant choice is the Participant Choice Statement. Individuals are required to document his/her choice via a dated signature on the form, which is also signed and dated by the individual performing the assessment. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years in the HCBS Web Tool. Participants are also provided with a signed copy.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are

maintained.

Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years in the HCBS Web Tool. Participants are also provided with a signed copy.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Interpreter services are available at no cost to the individual. Forms and information will be made available in alternate languages as needed and appropriate, interpretive language services will be provided for effective communication between the assessor and persons with Limited English Proficiency to facilitate participation in, and meaningful access to services.

Applicants for, or recipients of, services from the Department of Health and Senior Services (DHSS) or services funded through DHSS, are treated equitably regardless of age, ancestry, color, disability, national origin, race, religion, sex, sexual orientation, or veteran status. Appropriate interpretive services will be provided as required for the visually or hearing impaired and for persons with language barriers. Anyone who requires an auxiliary aid or service for effective communication, or a modification of policies or procedures to participate in a program, service, or activity of DHSS should notify DHSS as soon as possible, and no later than 48 hours before the scheduled event.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Adult Day Care**		
Statutory Service	**Basic Respite**		
Statutory Service	**Homemaker**		
Other Service	**Advanced Respite**		
Other Service	**Chore**		
Other Service	**Home Delivered Meal**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
The continuous care and supervision of disabled adult in a licensed adult day care (ADC) program. Services include but are not limited to assistance with activities of daily living, planned group activities, food services, participant observation, skilled nursing services as specified in the plan of care, and transportation. Planned group activities include socialization, recreation and cultural activities that stimulate the individual and help the participant maintain optimal functioning. The provider must arrange or provide transportation to the ADC setting at no cost to the participant. Reimbursement will be made for up to 120 minutes per day of transportation that is related to transporting an individual to and from the ADC setting. Meals provided as part of ADC setting shall not constitute a "full nutritional regimen" (3 meals per day).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services are limited as follows:
1) Up to 10 hours per day for a maximum of 5 days per week of which no more than eight(8), 15 minute units per day may be related to transporting an individual to and from the adult day care setting.
2) Aged and Disabled Waiver, ADC services in conjunction with other Aged and Disabled Waiver services and State Plan Personal Care program may not exceed 100% of the average monthly nursing facility cost of care established by the state each year, effective July 1st.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Adult Day Care Facilities

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:
Agency
Provider Type:
Licensed Adult Day Care Facilities
Provider Qualifications
License *(specify):*
Providers of adult day care services are required to be licensed by the Department of Health and Senior Services (DHSS)and must meet the requirements of State Statute 192, RSMo before applying for enrollment with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC) to be an Aged and Disabled Waiver provider. The regulation and statute is available to CMS upon request.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Senior Services
Frequency of Verification:
Relicensure inspections every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Respite
Alternate Service Title (if any):
Basic Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Basic Respite care services are maintenance and supervisory services provided to a participant with nonskilled needs in that individual's home because of the absence or need for relief of those persons who normally provide care for the participant. This service encompasses all the needs of a participant that might come up during the service provision that fall under supervision, companionship and direct participant assistance, all the services that are required to maintain the participant in his/her home. Federal financial participation is not claimed for the cost of room and board within this service. Basic Respite is provided in 15-minute units. The established service planning and prior authorization processes ensure that Basic Respite does not overlap any of the other respite services that can be authorized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Aged and Disabled Waiver Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Basic Respite

Provider Category:
Agency
Provider Type:
Aged and Disabled Waiver Provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A

Other Standard *(specify):*
A provider of this waiver service must comply with the requirements specified in 19 CSR 15-7.021 In-Home Service Standards. Providers must have a written participation agreement (contract) with the Department of Social Services (DSS) in order to enroll as an Aged and Disabled Waiver provider in the MO HealthNet Program. In order to qualify for a written participation agreement (contract), the waiver provider shall demonstrate, via the process described in the Entity Responsible for Verification section, that the provider meets the requirements in 19 CSR 15-7.021 which include, but are not limited to:(1) Maintain employment of and identify to the Department of Social Services (DSS) a designated manager. The designated manager shall be responsible for the provider's day-to-day operation; shall be a policy maker and direct the provider's record keeping, service delivery verification, hiring and firing practices and staff training. The provider shall ensure that the designated manager successfully completes (or has completed) a division provider training course offered quarterly or as needed at no charge.(2) Employ an RN or designate an RN as a consultant who will be primarily responsible for ensuring that policies and procedures of the in-home service provider meet the clinical standards for proper care of clients, training of staff, and general clinical integrity of the in-home service provider.(3) Employ and train the staff necessary to provide the required services and make staff available to serve in all sections of the provider's designated service area.(4) Successfully contact at least two (2) credible references for each employee prior to client contact.(5)Monitor a current copy of DHSS' Employee Disqualification List (EDL) to ensure that no current or prospective employee's name appears on the list and discharge any such employee once it is discovered by the provider that the employee is on the EDL. Prior to employment providers must screen prospective employees through the Family Care Safety Registry (FCSR) to ensure they have no disqualifying crimes. (6) Have the capability to provide service outside of regular business hours, on weekends and on holidays as authorized by DSDS. (7) Maintain a commercial general liability insurance policy in full force and effect that covers all places of business and any and all clients, customers, employees and volunteers. The policy shall be an occurrence policy and shall provide coverage for no less than one (1) million dollars per event and three (3) million dollars aggregate and shall include coverage for negligent acts and omissions of the provider's employees and volunteers in the provision of services to clients in such clients' homes. The policy shall name DSS as a certificate holder.(8) Providers shall maintain a professional liability insurance policy; criteria the same as the required commercial general liability insurance policy.(9) Providers shall maintain an employee dishonesty bond covering employees and volunteers who are connected with the delivery and performance of in-home services in the clients' homes.(10) Furnish adequate (permanent format including the provider's name and employee's name and title) identification (ID) to all employees.(11) Have and enforce a written code of ethics which is distributed to all employees and clients. (12) Ensure prompt initiation of authorized services to new clients. The provider shall deliver the in-home service within seven (7) calendar days of receipt of the service authorization from DSDS or on the beginning date specified by the authorization, whichever is later, and on a regular basis after that in accordance with the care plan. (13) Recommend changes to the authorized care plan any time the client has an ongoing need for service activities which may require more or fewer units than the amount specified in the care plan. For decreases in units only, change requests must be made in writing. (14) Keep documentation of undelivered services, including the reason for this failure to deliver authorized units.(15) Shall provide a written statement of the client's rights and review the statement with each client and primary caregiver, when appropriate at the time service is initiated. Client rights shall also include information about the provider's established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution.(16) Report all instances of potential abuse, neglect, exploitation of a client, or any combination of these, to DSDS' Elder Abuse and Neglect hotline, including all instances that may involve an employee of the provider agency(17) Shall designate trainer(s) to perform the sessions required as part of the basic training for staff.(18) Establish, enforce and implement a policy whereby all contents of the personnel files of its employees are made available to DHSS and/or DSS employees or representatives when requested as part of an official investigation of abuse, neglect, financial exploitation, misappropriation of client's funds or property, or falsification of documentation which verifies service delivery.(19) Have established policies to promote the safety of its employees. In addition to any employment requirements mentioned above, direct care staff providing respite services must be at least eighteen (18) years of age; be able to read, write and follow directions; and have at least six (6) months paid work experience as an agency homemaker, nurse aide, maid or household worker - or - at least one (1) years experience, paid or unpaid, in caring for children or for sick or aged individuals - or - successful completion of formal

training in nursing arts or as a nurse aide or home health aide. Training is required for direct care staff providing basic respite services as follows: (1) Twenty (20) hours of orientation training, including at least two (2) hours orientation to the provider agency and the agency's protocols for handling emergencies, within thirty (30) days of employment. Eight (8) hours of this training will be provided prior to the first day of client contact. New employee orientation curricula shall include an overview of Alzheimer's disease and related dementias and methods of communicating with persons with dementia.(2) Ten (10) hours of in-service training shall be provided annually after the first twelve (12) months of employment. In-service training curricular shall include updates on Alzheimer's disease and related dementia.

Verification of Provider Qualifications

Entity Responsible for Verification:

Prospective waiver providers are required to submit a detailed, written proposal to DSS, MMAC Unit, the unit responsible for monitoring the MO HealthNet program as administered through the DHSS, DSDS. The DHSS, DSDS administers the Social Services Block Grant/General Revenue (SSBG/GR) in-home services program: state plan Personal Care and Aged and Disabled Waiver. All providers are screened prior to being enrolled via a paper review by the DSS, MMAC Provider Contracts Section of the submitted paper records to determine whether or not the prospective waiver provider has made credible assurances that services will be delivered in accordance with program standards, that services will be properly documented, and that all participant safety assurances are made in writing. Prior to approval of the written proposal the DSS, MMAC Unit makes an on-site visit to the prospective provider's place of business. If a prospective provider is approved for issuance of a Participation Agreement (contract) with DSS, MMAC, the prospective provider is also deemed eligible to enroll for MO HealthNet reimbursement as an Aged and Disabled Waiver provider.

Frequency of Verification:

Proposals are initially reviewed when the prospective provider submits the application proposal for a participation agreement. Providers must submit certain required information as designated by the DSS, MMAC in order to be eligible for Participation Agreement (contract) renewal. Each provider is also screened annually against the HHS OIG's List of Excluded Individuals/Entities (LEIE) during the Participation Agreement (contract) renewal process as well as during the proposal review process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker

Category 2:	Sub-Category 2:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services that consist of the peformance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
N/A

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Aged and Disabled Waiver

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Aged and Disabled Waiver
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
A provider of this waiver service must comply with the requirements specified in 19 CSR 15-7.021 In-Home Service Standards. Providers must have a written participation agreement (contract) with the Department of Social Services (DSS) in order to enroll as an Aged and Disabled Waiver provider

in the MO HealthNet Program. In order to qualify for a written participation agreement (contract), the waiver provider shall demonstrate, via the process described in the Entity Responsible for Verification section, that the provider meets the requirements in 19 CSR 15-7.021 which include, but are not limited to:(1) Maintain employment of and identify to the Department of Social Services (DSS) a designated manager. The designated manager shall be responsible for the provider's day-to-day operation; shall be a policy maker and direct the provider's record keeping, service delivery verification, hiring and firing practices and staff training. The provider shall ensure that the designated manager successfully completes (or has completed) a division provider training course offered quarterly or as needed at no charge.(2) Employ an RN or designate an RN as a consultant who will be primarily responsible for ensuring that policies and procedures of the in-home service provider meet the clinical standards for proper care of clients, training of staff, and general clinical integrity of the in-home service provider.(3) Employ and train the staff necessary to provide the required services and make staff available to serve in all sections of the provider's designated service area.(4) Successfully contact at least two (2) credible references for each employee prior to client contact.(5)Monitor a current copy of DHSS' Employee Disqualification List (EDL) to ensure that no current or prospective employee's name appears on the list and discharge any such employee once it is discovered by the provider that the employee is on the EDL. Prior to employment providers must screen prospective employees through the Family Care Safety Registry (FCSR) to ensure they have no disqualifying crimes. (6) Have the capability to provide service outside of regular business hours, on weekends and on holidays as authorized by DSDS. (7) Maintain a commercial general liability insurance policy in full force and effect that covers all places of business and any and all clients, customers, employees and volunteers. The policy shall be an occurrence policy and shall provide coverage for no less than one (1) million dollars per event and three (3) million dollars aggregate and shall include coverage for negligent acts and omissions of the provider's employees and volunteers in the provision of services to clients in such clients' homes. The policy shall name DSS as a certificate holder.(8) Providers shall maintain a professional liability insurance policy; criteria the same as the required commercial general liability insurance policy.(9) Providers shall maintain an employee dishonesty bond covering employees and volunteers who are connected with the delivery and performance of in-home services in the clients' homes.(10) Furnish adequate (permanent format including the provider's name and employee's name and title) identification (ID) to all employees.(11) Have and enforce a written code of ethics which is distributed to all employees and clients. (12) Ensure prompt initiation of authorized services to new clients. The provider shall deliver the in-home service within seven (7) calendar days of receipt of the service authorization from DSDS or on the beginning date specified by the authorization, whichever is later, and on a regular basis after that in accordance with the care plan. (13) Recommend changes to the authorized care plan any time the client has an ongoing need for service activities which may require more or fewer units than the amount specified in the care plan. For decreases in units only, change requests must be made in writing. (14) Keep documentation of undelivered services, including the reason for this failure to deliver authorized units.(15) Shall provide a written statement of the client's rights and review the statement with each client and primary caregiver, when appropriate at the time service is initiated. Client rights shall also include information about the provider's established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution.(16) Report all instances of potential abuse, neglect, exploitation of a client, or any combination of these, to DSDS' Elder Abuse and Neglect hotline, including all instances that may involve an employee of the provider agency(17) Shall designate trainer(s) to perform the sessions required as part of the basic training for staff.(18) Establish, enforce and implement a policy whereby all contents of the personnel files of its employees are made available to DHSS and/or DSS employees or representatives when requested as part of an official investigation of abuse, neglect, financial exploitation, misappropriation of client's funds or property, or falsification of documentation which verifies service delivery.(19) Have established policies to promote the safety of its employees. In addition to any employment requirements mentioned above, direct care staff providing respite services must be at least eighteen (18) years of age; be able to read, write and follow directions; and have at least six (6) months paid work experience as an agency homemaker, nurse aide, maid or household worker - or - at least one (1) years experience, paid or unpaid, in caring for children or for sick or aged individuals - or - successful completion of formal training in nursing arts or as a nurse aide or home health aide. Training is required for direct care staff providing basic respite services as follows: (1) Twenty (20) hours of orientation training, including at least two (2) hours orientation to the provider agency and the agency's protocols for handling emergencies, within thirty (30) days of employment. Eight (8) hours of this training will be provided

prior to the first day of client contact. New employee orientation curricula shall include an overview of Alzheimer's disease and related dementias and methods of communicating with persons with dementia.(2) Ten (10) hours of in-service training shall be provided annually after the first twelve (12) months of employment. In-service training curricular shall include updates on Alzheimer's disease and related dementia.

Verification of Provider Qualifications

Entity Responsible for Verification:

Prospective waiver providers are required to submit a detailed, written proposal to DSS, MMAC Unit, the unit responsible for monitoring the MO HealthNet program as administered through the DHSS, DSDS. The DHSS, DSDS administers the Social Services Block Grant/General Revenue (SSBG/GR) in-home services program: state plan Personal Care and Aged and Disabled Waiver. All providers are screened prior to being enrolled via a paper review by the DSS, MMAC Provider Contracts Section of the submitted paper records to determine whether or not the prospective waiver provider has made credible assurances that services will be delivered in accordance with program standards, that services will be properly documented, and that all participant safety assurances are made in writing. Prior to approval of the written proposal the DSS, MMAC Unit makes an on-site visit to the prospective provider's place of business. If a prospective provider is approved for issuance of a Participation Agreement (contract) with DSS, MMAC, the prospective provider is also deemed eligible to enroll for MO HealthNet reimbursement as an Aged and Disabled Waiver provider.

Frequency of Verification:

Proposals are initially reviewed when the prospective provider submits the application proposal for a participation agreement. Providers must submit certain required information as designated by the DSS, MMAC in order to be eligible for Participation Agreement (contract) renewal. Each provider is also screened annually against the HHS OIG's List of Excluded Individuals/Entities (LEIE) during the Participation Agreement (contract) renewal process as well as during the proposal review process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Advanced Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Advanced Respite care services are maintenance and supervisory services provided to a participant with nonskilled needs that require specialized training in that individual's home because of the absence or need for relief of those persons who normally provide care for the participant. This service encompasses all the needs of a participant that might come up during the service provision that fall under supervision, companionship, and direct participant assistance, all the services that are required to maintain the participant in his/her home. Federal financial participation is not claimed for the cost of room and board within this service. Advanced Respite is provided in 15-minute units.

Participants appropriate for Advanced Respite care include, but are not limited to:
(1) participants who are essentially bedfast, and require specialized care involving turning and position, including assistance witn mechanical transfer equipment and/or assistance with elimination, including the use of a urinal, bed pan, catheter and/or ostomy
(2) participants who have behavior disorders resulting in disruptive behavior especially due to Alzheimer's disease which requires close monitoring
(3) participants who have health problems requiring manual assistance with oral medications
(4) participants who have special monitoring and assistance needs due to swallowing problems.

The established service planning and prior authorization processes ensure that Advanced Respite does not overlap any of the other six respites that can be authorized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Aged and Disabled Waiver Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Advanced Respite

Provider Category:
Agency

Provider Type:
Aged and Disabled Waiver Provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
A provider of this waiver service must comply with the requirements specified in 19 CSR 15-7.021 In-Home Service Standards. Providers must have a written participation agreement (contract) with the Department of Social Services (DSS) in order to enroll as an Aged and Disabled Waiver provider in the MO HealthNet Program. In order to qualify for a written participation agreement (contract), the waiver provider shall demonstrate, via the process described in the Entity Responsible for Verification section, that the provider meets the requirements in 19 CSR 15-7.021 which include, but are not limited to:(1) Maintain employment of and identify to the Department of Social Services (DSS) a designated manager. The designated manager shall be responsible for the provider's day-to-day operation; shall be a policy maker and direct the provider's record keeping, service delivery verification, hiring and firing practices and staff training. The provider shall ensure that the designated manager successfully completes (or has completed) a division provider training course offered quarterly or as needed at no charge.(2) Employ an RN or designate an RN as a consultant who will be primarily responsible for ensuring that policies and procedures of the in-home service provider meet the clinical standards for proper care of clients, training of staff, and general clinical integrity of the in-home service provider.(3) Employ and train the staff necessary to provide the required services and make staff available to serve in all sections of the provider's designated service area.(4) Successfully contact at least two (2) credible references for each employee prior to client contact.(5)Monitor a current copy of DHSS' Employee Disqualification List (EDL) to ensure that no current or prospective employee's name appears on the list and discharge any such employee once it is discovered by the provider that the employee is on the EDL. Prior to employment providers must screen prospective employees through the Family Care Safety Registry (FCSR) to ensure they have no disqualifying crimes. (6) Have the capability to provide service outside of regular business hours, on weekends and on holidays as authorized by DSDS. (7) Maintain a commercial general liability insurance policy in full force and effect that covers all places of business and any and all clients, customers, employees and volunteers. The policy shall be an occurrence policy and shall provide coverage for no less than one (1) million dollars per event and three (3) million dollars aggregate and shall include coverage for negligent acts and omissions of the provider's employees and volunteers in the provision of services to clients in such clients' homes. The policy shall name DSS as a certificate holder.(8) Providers shall maintain a professional liability insurance policy; criteria the same as the required commercial general liability insurance policy.(9) Providers shall maintain an employee dishonesty bond covering employees and volunteers who are connected with the delivery and performance of in-home services in the clients' homes.(10) Furnish adequate (permanent format including the provider's name and employee's name and title) identification (ID) to all employees.(11) Have and enforce a written code of ethics which is distributed to all employees and clients. (12) Ensure prompt initiation of authorized services to new clients. The provider shall deliver the in-home service within seven (7) calendar days of receipt of the service authorization from DSDS or on the beginning date specified by the authorization, whichever is later, and on a regular basis after that in accordance with the care plan. (13) Recommend changes to the authorized care plan any time the client has an ongoing need for service activities which may require more or fewer units than the amount specified in the care plan. For decreases in units only, change requests must be made in writing. (14) Keep documentation of undelivered services, including the reason for this failure to deliver authorized units.(15) Shall provide a written statement of the client's rights and review the statement with each client and primary caregiver, when appropriate at the time service is initiated. Client rights shall also include information about the provider's established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution.(16) Report all instances of potential abuse, neglect, exploitation of a client, or any combination of these, to DSDS' Elder Abuse and Neglect hotline, including all instances that may involve an employee of the provider agency(17) Shall designate trainer(s) to perform the sessions required as part of the basic training for staff.(18) Establish, enforce and implement a policy whereby all contents of the personnel files of its employees are made available to DHSS and/or DSS employees or representatives when requested as part of an official

investigation of abuse, neglect, financial exploitation, misappropriation of client's funds or property, or falsification of documentation which verifies service delivery.(19) Have established policies to promote the safety of its employees. In addition to any employment requirements mentioned above, direct care staff providing respite services must be at least eighteen (18) years of age; be able to read, write and follow directions; and have at least six (6) months paid work experience as an agency homemaker, nurse aide, maid or household worker - or - at least one (1) years experience, paid or unpaid, in caring for children or for sick or aged individuals - or - successful completion of formal training in nursing arts or as a nurse aide or home health aide. Training is required for direct care staff providing basic respite services as follows: (1) Twenty (20) hours of orientation training, including at least two (2) hours orientation to the provider agency and the agency's protocols for handling emergencies, within thirty (30) days of employment. Eight (8) hours of this training will be provided prior to the first day of client contact. New employee orientation curricula shall include an overview of Alzheimer's disease and related dementias and methods of communicating with persons with dementia.(2) Ten (10) hours of in-service training shall be provided annually after the first twelve (12) months of employment. In-service training curricular shall include updates on Alzheimer's disease and related dementia.

Additional training requirements for in-home workers providing advanced respite care must be determined and provided by a provider agency RN following assessment of the client's condition and needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Prospective waiver providers are required to submit a detailed, written proposal to DSS, MMAC Unit, the unit responsible for monitoring the MO HealthNet program as administered through the DHSS, DSDS. The DHSS, DSDS administers the Social Services Block Grant/General Revenue (SSBG/GR) in-home services program: state plan Personal Care and Aged and Disabled Waiver. All providers are screened prior to being enrolled via a paper review by the DSS, MMAC Provider Contracts Section of the submitted paper records to determine whether or not the prospective waiver provider has made credible assurances that services will be delivered in accordance with program standards, that services will be properly documented, and that all participant safety assurances are made in writing. Prior to approval of the written proposal the DSS, MMAC Unit makes an on-site visit to the prospective provider's place of business. If a prospective provider is approved for issuance of a Participation Agreement (contract) with DSS, MMAC the prospective provider is also deemed eligible to enroll for MO HealthNet reimbursement as an Aged and Disabled Waiver provider.

Frequency of Verification:

Proposals are initially reviewed when the prospective provider submits the application proposal for a participation agreement. Providers must submit certain required information as designated by the DSS, MMAC in order to be eligible for Participation Agreement (contract) renewal. Each provider is also screened annually against the HHS OIG's List of Excluded Individuals/Entities (LEIE) during the Participation Agreement (contract) renewal process as well as during the proposal review process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

08 Home-Based Services | 08060 chore

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Chore services are short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment and determined by Division of Senior and Disability Services (DSDS) staff to be critical in maintaining the participant''s health and safety. Chore services shall be provided only when the participant or other household member is incapable of performing or financially providing for them, and when no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of or responsible for providing such tasks. Chore services include the following: wash walls and woodwork; clean closets, basements and attics; shampoo rugs; air mattresses and bedding; spray for insects within the home with over-the-counter supplies; and provide rodent control within the home (for example, setting traps and putting out over-the-counter supplies).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Aged and Disabled Waiver Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Chore

Provider Category:

Agency

Provider Type:

Aged and Disabled Waiver Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

A provider of this waiver service must comply with the requirements specified in 19 CSR 15-7.021 In-Home Service Standards. Providers must have a written participation agreement (contract) with the Department of Social Services (DSS) in order to enroll as an Aged and Disabled Waiver provider in the MO HealthNet Program. In order to qualify for a written participation agreement (contract), the waiver provider shall demonstrate, via the process described in the Entity Responsible for Verification section, that the provider meets the requirements in 19 CSR 15-7.021 which include, but are not limited to:(1) Maintain employment of and identify to the Department of Social Services (DSS) a designated manager. The designated manager shall be responsible for the provider's day-to-day operation; shall be a policy maker and direct the provider's record keeping, service delivery verification, hiring and firing practices and staff training. The provider shall ensure that the designated manager successfully completes (or has completed) a division provider training course offered quarterly or as needed at no charge.(2) Employ an RN or designate an RN as a consultant who will be primarily responsible for ensuring that policies and procedures of the in-home service provider meet the clinical standards for proper care of clients, training of staff, and general clinical integrity of the in-home service provider.(3) Employ and train the staff necessary to provide the required services and make staff available to serve in all sections of the provider's designated service area.(4) Successfully contact at least two (2) credible references for each employee prior to client contact.(5)Monitor a current copy of DHSS' Employee Disqualification List (EDL) to ensure that no current or prospective employee's name appears on the list and discharge any such employee once it is discovered by the provider that the employee is on the EDL. Prior to employment providers must screen prospective employees through the Family Care Safety Registry (FCSR) to ensure they have no disqualifying crimes. (6) Have the capability to provide service outside of regular business hours, on weekends and on holidays as authorized by DSDS. (7) Maintain a commercial general liability insurance policy in full force and effect that covers all places of business and any and all clients, customers, employees and volunteers. The policy shall be an occurrence policy and shall provide coverage for no less than one (1) million dollars per event and three (3) million dollars aggregate and shall include coverage for negligent acts and omissions of the provider's employees and volunteers in the provision of services to clients in such clients' homes. The policy shall name DSS as a certificate holder.(8) Providers shall maintain a professional liability insurance policy; criteria the same as the required commercial general liability insurance policy.(9) Providers shall maintain an employee dishonesty bond covering employees and volunteers who are connected with the delivery and performance of in-home services in the clients' homes.(10) Furnish adequate (permanent format including the provider's name and employee's name and title) identification (ID) to all employees.(11) Have and enforce a written code of ethics which is distributed to all employees and clients. (12) Ensure prompt initiation of authorized services to new clients. The provider shall deliver the in-home service within seven (7) calendar days of receipt of the service authorization from DSDS or on the beginning date specified by the authorization, whichever is later, and on a regular basis after that in accordance with the care plan. (13) Recommend changes to the authorized care plan any time the client has an ongoing need for service activities which may require more or fewer units than the amount specified in the care plan. For decreases in units only, change requests must be made in writing. (14) Keep documentation of undelivered services, including the reason for this failure to deliver authorized units.(15) Shall provide a written statement of the client's rights and review the statement with each client and primary caregiver, when appropriate at the time service is initiated. Client rights shall also include information about the provider's established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution.(16) Report all instances of potential abuse, neglect, exploitation of a client, or any combination of these, to DSDS' Elder Abuse and Neglect hotline,

including all instances that may involve an employee of the provider agency(17) Shall designate trainer(s) to perform the sessions required as part of the basic training for staff.(18) Establish, enforce and implement a policy whereby all contents of the personnel files of its employees are made available to DHSS and/or DSS employees or representatives when requested as part of an official investigation of abuse, neglect, financial exploitation, misappropriation of client's funds or property, or falsification of documentation which verifies service delivery.(19) Have established policies to promote the safety of its employees. In addition to any employment requirements mentioned above, direct care staff providing respite services must be at least eighteen (18) years of age; be able to read, write and follow directions; and have at least six (6) months paid work experience as an agency homemaker, nurse aide, maid or household worker - or - at least one (1) years experience, paid or unpaid, in caring for children or for sick or aged individuals - or - successful completion of formal training in nursing arts or as a nurse aide or home health aide. Training is required for direct care staff providing basic respite services as follows: (1) Twenty (20) hours of orientation training, including at least two (2) hours orientation to the provider agency and the agency's protocols for handling emergencies, within thirty (30) days of employment. Eight (8) hours of this training will be provided prior to the first day of client contact. New employee orientation curricula shall include an overview of Alzheimer's disease and related dementias and methods of communicating with persons with dementia.(2) Ten (10) hours of in-service training shall be provided annually after the first twelve (12) months of employment. In-service training curricular shall include updates on Alzheimer's disease and related dementia.

Verification of Provider Qualifications

Entity Responsible for Verification:

Prospective waiver providers are required to submit a detailed, written proposal to DSS, MMAC Unit, the unit responsible for monitoring the MO HealthNet program as administered through the DHSS, DSDS. The DHSS, DSDS administers the Social Services Block Grant/General Revenue (SSBG/GR) in-home services program: state plan Personal Care and Aged and Disabled Waiver. All providers are screened prior to being enrolled via a paper review by the DSS, MMAC Provider Contracts Section of the submitted paper records to determine whether or not the prospective waiver provider has made credible assurances that services will be delivered in accordance with program standards, that services will be properly documented, and that all participant safety assurances are made in writing. Prior to approval of the written proposal the DSS, MMAC Unit makes an on-site visit to the prospective provider’s place of business. If a prospective provider is approved for issuance of a Participation Agreement (contract) with DSS, MMAC, the prospective provider is also deemed eligible to enroll for MO HealthNet reimbursement as an Aged and Disabled Waiver provider.

Frequency of Verification:

Proposals are initially reviewed when the prospective provider submits the application proposal for a participation agreement. Providers must submit certain required information as designated by the DSS, MMAC in order to be eligible for Participation Agreement (contract) renewal. Each provider is also screened annually against the HHS OIG's List of Excluded Individuals/Entities (LEIE) during the Participation Agreement (contract) renewal process as well as during the proposal review process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meal

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

06 Home Delivered Meals | 06010 home delivered meals

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Home Delivered Meal is a service to provide aged and disabled individuals with one (1) or two (2) meals per day. Each meal contains at least one-third (1/3) of the recommended daily nutritional requirements. The meals are delivered to individuals who would require nursing facility level of care but for the provision of such services. Meal preparation by Aged and Disabled Waiver providers (with food purchased by the waiver participant) may be authorized in the plan of care for those meals not provided under the home delivered meals service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
No more than two (2) home delivered meals will be authorized for each day.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	ADW Home Delivered Meal Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meal

Provider Category:
Agency

Provider Type:
ADW Home Delivered Meal Provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
A provider of this waiver service must comply with the requirements specified in 19 CSR 15-4.240 Nutrition Service Requirements, 19 CSR 15-7.010 General Requirements of All Service Providers, 19 CSR 15-7.060 Nutrition Service Standards, and the Older Americans Act, PL 114-144, as amended in 2016. Providers must have a written contract with the Department of Health and Senior Services in order to enroll as an ADW Home Delivered Meal (HDM) provider with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC). The ADW HDM provider shall demonstrate, via the process described in the Scope of Work section, that the provider meets the requirements in the regulations listed above which include, but are not limited to:

1) HDM providers shall provide services and meet all requirements set forth in 19 CSR 15-7.010.
2) HDM providers shall provide an assurance in their area plans that any person who provides or applies to provide direct services in the home will be checked against the Family Care Safety Registry and Employee Disqualification List.
3) There shall be an administrator who shall be responsible for the operation of the service center and the service. The administrator, or a person designated by the administrator, shall be present in the service center at all times the service center is open.
4) There shall be an adequate number of staff (paid or volunteer) who are qualified to perform assigned functions in order to implement the activities and services of the service center.
5) Administrator—: six (6) hours of orientation plus twelve (12) hours of supervised on the- job training and an additional four (4) hours of in-service training per quarter or sixteen (16) hours annually.
6) Cook: —four (4) hours of orientation plus six (6) hours of supervised on-the-job training and additional two (2) hours of in-service training per quarter or eight (8) hours annually.
7) Cook helper—: two (2) hours of orientation plus four (4) hours of supervised on-the job training and an additional one (1) hour in service training per quarter or four (4) hours annually.
8) Record Keeping: The following additional records shall be maintained by HDM providers: a) daily record documenting participants who receive meals following a method developed by the provider and approved by the Division of Senior and Disability Services (DSDS); b) meal count or reports, including total United States Department of Agriculture (USDA)-eligible meals, USDA-eligible meals served to low-income elderly minority persons, meals served to handicapped persons eighteen to fifty-nine (18–59) and meals ineligible guests and staff; c) perpetual and physical inventory records for all foods; and d) food cost records.
9) Each home-delivered meals provider shall provide nutrition education materials to homebound recipients on a quarterly basis, and
A: Meet the most recent Dietary Guidelines for Americans, published by the Secretaries of Health and Human Services and Agriculture, and
B: Provide to each participating individual a minimum of one-third of the Dietary Reference Intakes, established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, if one meal is served, two-thirds if two meals are served, and 100 percent if 3 meals are served; and
10) Each home-delivered meal provider shall comply with applicable provisions of state and local food service laws.
11) A twenty to twenty-eight (20–28) day menu cycle shall be developed to be repeated for a three (3) month period. Suggestions from service recipients shall be solicited regarding menu choices.
12) Standardized recipes shall be used to assure consistent quality and quantity.
13) Menus shall be reviewed and certified by a nutritionist or dietitian. This individual must meet the standards set forth in 19 CSR 15-4.240(12). Copies of all certified menus shall be maintained for at least one (1) year.
14) Menu substitutions shall be made in accordance with the established procedures.
15) Menus shall conform to the meal patterns and principles of menu planning provided by DSDS.
16) Special menus shall be provided to meet the particular dietary needs arising from the health

requirements, religious requirements or ethnic backgrounds of service recipients, where appropriate.
17) Special meals provided for health requirements shall be planned, prepared and served under the supervision/consultation of a dietitian.
18) The person(s) responsible for the service of special diets shall be trained to make appropriate substitutions based on food values.
19) Diet counseling, if provided, shall be conducted by a dietitian, according to the participant's diet prescription which shall be obtained from the participant's physician;
20) A diet prescription may be obtained for participants receiving home-delivered special meals. Any prescription on file shall be kept current and shall be reviewed at least annually with the participant's physician;
21) Participants with a strict dietary regimen shall be referred to a medical professional management of dietary needs; and
22) The current Dietary Guidelines for Americans shall be used as a reference in developing special diets.

Verification of Provider Qualifications

Entity Responsible for Verification:
Home Delivered Meal providers are required to annually submit detailed plans and amendments to DSDS. DSDS staff determine whether or not the provider has made credible assurances that services will be provided in accordance to program standards, that services will be properly documented, and that all participant safety assurances are made in writing.

Frequency of Verification:
Service plans are reviewed annually and amendments are reviewed as they are provided. Providers must submit monthly service reports verifying the number of participants served, units provided and dollar amount of service. Annual on-site monitoring visits are conducted to verify providers are monitoring any sub-contracted providers and are meeting the rules and regulations' governing their service plans.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- (●) **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ( ) **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - [ ] **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - [ ] **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - [ ] **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - [ ] **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All positions that have contact with the enrolled participant require a Missouri background investigation through DHSS. These background investigations are completed by the provider on their employees.

Providers are responsible for requesting state criminal/background investigations on staff providing direct care to waiver eligible participants prior to employment. Providers request these investigations through the Family Care Safety Registry which helps protect participants by compiling and providing access to background information.

Criminal background checks may be submitted directly to the MO State Highway Patrol in accordance with requirements of Chapter 43,RSMo;

Employee Disqualification List checks may be submitted directly to the Missouri Department of Health and Senior Services (DHSS) as provided in section 192.2490, RSMo;

The Registry accesses the following background information from Missouri Data ONLY, and through the following cooperating state agencies:
1) State criminal background records maintained by the Missouri State Highway Patrol
2) Sex Offender Registry information maintained by the Missouri State Highway Patrol
3) Child abuse/neglect records maintained by the Missouri Department of Social Services
4) The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
5) The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
6) Child-Care facility licensing records maintained by the Missouri Department of Health and Senior Services
7) Foster parent licensing records maintained by the Missouri Department of Social Services

Providers are also required to make periodic checks of the Employee Disqualification List, maintained by the Missouri Department of Health and Senior Services, to determine whether any current employee, contractor or volunteer has been recently added to the list.

Missouri Medicaid Audit & Compliance (MMAC) is responsible for monitoring providers to assure that background investigations are conducted as required by statute and regulation. This monitoring will be conducted during regular monitoring visits, requested technical assistance visits and complaint investigations. Monitoring providers for compliance will be conducted during regular monitoring visits and complaint investigations. MMAC verifies every three years during the post payment review.

Providers are required to perform abuse registry screening on all staff employed by the provider. The Missouri Medicaid Audit and Compliance (MMAC) Unit ensure that mandatory investigations have been conducted.

ADC Waiver providers are required to perform abuse registry screening on all staff employed by the provider.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

○ **No. The State does not conduct abuse registry screening.**

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Department of Health and Senior Services (DHSS) is responsible for maintaining the Employee Disqualification List (EDL) and the Family Care Safety Registry (FCSR)(explained in C-2-a). No person is allowed to be employed to work or allowed to volunteer in any capacity in any Aged and Disabled Waiver (ADW) program that left or was discharged from employment with any other employer due to abuse or neglect to patients, participants or clients and the dismissal or departure has not been reversed by any tribunal or agency. Each ADW waiver provider is required to complete an EDL screening and a criminal record review through the Missouri State Highway Patrol for all new applicants for employment in positions involving contact with participants. ADW Home Delivered Meal Providers are required to perform abuse registry screening on all staff providing direct services to waiver participants. The ADW Waiver provider is also required to make periodic checks of the EDL to determine whether any current employee, contractor or volunteer has been recently added to the list. DHSS produces an annual list in January of each year. Updates are added to the web site each quarter which list all individuals who have been added to or deleted from the EDL during the preceding three months. MMAC is responsible for monitoring the waiver providers to assure that mandatory abuse screenings are conducted as required by statute and regulation. This monitoring will be conducted during the audit process.

The Department of Health and Senior Services will review Adult Day Care providers for compliance with mandatory screenings during the initial and re-licensure inspection process.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- (•) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

  State adult day care licensure laws do not restrict relatives or legal guardians from the provision of adult day care services to relatives as long as services are provided in accordance with state licensure laws governing adult day care and the individual meets all provider qualification. This includes owner/operator and/or employees of the adult day care program where a waiver participant receives waiver adult day care services.

- ( ) **Other policy.**

  Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Interested providers contact Missouri Medicaid Audit & Compliance (MMAC), Provider Enrollment Unit. Any provider who meets provider qualifications is allowed to enroll. Specific criteria regarding programs and provider enrollment requirements are available to all individuals through MMAC at http://mmac.mo.gov.

There are several statewide Associations for the home and community-based services industry which provide additional information to association members regarding provider enrollment information.

There are no timeframes for provider enrollment. Open enrollment is ongoing throughout the year. Providers may contact the MO HealthNet Provider Enrollment Unit for information on how to enroll. Enrollment timeframes vary and are dependent upon the volume of requests for enrollment being processed by the Missouri Medicaid Audit and Compliance (MMAC) Provider Enrollment Unit.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the

State's methods for discovery and remediation.

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of newly enrolled Adult Day Care Providers that have the required license/certification prior to serving waiver participants. Numerator = Number of newly enrolled Adult Day Care Waiver Providers that have the required license/certification prior to serving waiver participants. Denominator = Total number of newly enrolled Adult Day Care Waiver Providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment Files

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of enrolled licensed Adult Day Care Providers (ADC) who were terminated by MMAC for not continuing to meet provider requirements following initial enrollment. Numerator = Number of ADC providers terminated by MMAC for not continuing to meet provider requirements following initial enrollment. Denominator = Total number of ADC providers that required termination.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider enrollment records.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of newly enrolled Aged and Disabled Waiver (ADW) providers (provider type 28) who met initial waiver provider qualifications prior to serving waiver participants. Numerator = Number of newly enrolled ADW providers that met initial waiver provider qualifications prior to serving waiver participants. Denominator = Total number of newly enrolled ADW providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Missouri Medicaid Audit and Compliance

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of Aged and Disabled Waiver (ADW) providers (provider type 28) terminated by MMAC for not continuing to meet provider requirements following initial enrollment. Numerator = Number of ADW providers terminated by MMAC for not continuing to meet provider requirements following initial enrollment. Denominator = Total number of ADW providers that required termination.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Missouri Medicaid Audit and Compliance

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of newly enrolled Adult Day Care providers who meet the training requirements of 19 CSR 30-090. Numerator = Number of newly enrolled Adult Day Care providers who meet the training requirements of 19 CSR 30-090. Denominator = Total number of newly enrolled Adult Day Care providers.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Every 2 years during relicensure	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of new Aged and Disabled Waiver (ADW) providers (provider type 28) that have someone on staff that has passed provider designated manager certification. Numerator = Number of new ADW providers that have someone on staff that has passed provider designated manager certification. Denominator = Total number of new ADW providers.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Missouri Medicaid Audit and Compliance

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Missouri Medicaid Audit and Compliance (MMAC) notifies the provider in writing immediately when problems are discovered. MMAC forwards a copy of the notification letter to MO HealthNet Division (MHD) and the Department of Health and Senior Services (DHSS) when actions are taken against a provider. Remediation may include recoupment of provider payments or termination of provider enrollment. MMAC monitors the provider for compliance. Information is provided to MHD and DHSS regarding the problems identified, remediation actions required and changes made by the provider to come into compliance. This information is tracked and trended to ensure problems are corrected.

As required by Section 192.2205, RSMo, DHSS conducts the onsite inspections needed to license Adult Day Care (ADC) programs to ensure they meet the minimum standards for insuring the health and safety of the participants. The Division of Regulation and Licensure (DRL), Section for Long Term Care Regulation (SLTCR) is divided into seven regional offices, where inspectors are employed to inspect ADC programs. When an individual ADC program is found out of compliance with a state regulation for ADC programs, the program director/designee is informed that he/she will receive a letter and a Statement of Deficiencies (SOD) from the regional office within ten (10) working days of the Exit Conference. The letter that accompanies the SOD outlines the outcome of the inspection and requests the director submit a plan of correction (POC) including time frames of that action. DHSS staff will review the POC to ensure it will be sufficient to correct the citation and prevent future reoccurrence.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.

- [ ] **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please see attachment #2 for the waiver specific transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Participant Choice Statement and the associated Prior Authorization - Care Plan from the HCBS Web Tool in conjunction with the InterRAI HC MO Version

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- [ ] **Social Worker**

  Specify qualifications:

- [x] **Other**

  Specify the individuals and their qualifications:

  Division of Senior and Disability Services staff, at a minimum, meet the following experience and educational requirements. One or more years of experience as an Adult Protective and Community Worker (APCW) I, Social Service Worker (SSW) I, or Children's Service Worker (CSW) I with the Missouri Uniform Classification

and Pay System; or an undergraduate degree from an accredited college or university in Social Work, Psychology, Sociology, Gerontology, Nursing, Health Science, Health Care Administration, Human Resources, Political Science, Anthropology, Human Services, Public Administration, Education, Counseling, Criminal Justice, or closely related field.

Position definition of those performing the initial evaluations are as followed:

APCW I(formerly SSW I): This is entry-level professional social service work in the Department of Health and Senior Services providing protective services and/or coordinating in-home services on behalf of senior and/or disabled adults.

CSW I (formerly SSW I): This is entry-level professional social service work in the Children's Division of the Department of Social Services providing protective services on behalf of children and families in instances of abuse, neglect, or exploitation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Qualified individuals who perform the assessment will review the list of available Home and Community Based Services (HCBS) (both State Plan and Waiver services) with each potential participant. The HCBS Web Tool provides all users a comprehensive definition of each HCBS which can then be provided to the potential participant and others involved in the development of the care plan. The participant signs the completed Participant Choice Statement to indicate his/her participation in the development of, and agreement with, the care plan. The signed document also provides a phone number of the appropriate DSDS Regional Evaluation Team for the participant to utilize when changes in circumstances occur that may affect the care plan. Discussions are then held with the participant to determine if care plan changes are necessary.

The Division of Senior and Disability Services (DSDS) recognizes participants and other individuals are an integral part of the service planning process. The participant is informed by qualified staff as specified in D-1-a, that s/he may elect to include anyone s/he wants to contribute to the discussions and the actual plan. Prior to initiation of the service plan development, services available through the Aged and Disabled Waiver are discussed with the participant and his/her invitees. Participant rights and responsibilities are discussed with the participant along with the appeal process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The care plan is developed at the time of the assessment or reassessment with the participant and anyone they choose. The participant is contacted to schedule an appointment convenient for the participant. This process allows the participant to have anyone they choose there during the care planning process. The care plan is updated when the Division of Senior and Disability Services (DSDS) staff are contacted by the provider or participant when there has been a change in the participant's circumstances or needs.
(b) The InterRAI HC is a comprehensive internationally recognized home care assessment that supports service plan development including the needs, preferences, goals, risks, and health status of the participant.
(c) The services available through the Aged and Disabled Waiver are described/explained to the participant and other attendees during the assessment and service plan development process. The actual provider is selected through the participant's choice and provider availability.
(d) During the comprehensive assessment, the goals, needs, and preferences of the participant are identified and addressed in the service plan. The InterRAI HC is comprehensive assessment tool which not only determines the Level of Care (LOC) of the individual, but looks at the participant risks and strengths as related to community living.

Although necessary at times, independent contact with other individuals shall not compromise the rights and preferences of the participants. If additional information gathered during the design of a service plan creates a discrepancy with the expressed wishes of a participant, additional discussions and documentation shall take place. Additional medical issues may be identified that require the participants to be informed of any potential barriers, which will prompt additional discussion about how to address these issues. Appropriate referrals are made to other resources necessary to assist the participant in achieving optimal independence. When the participant receives services from other agencies, coordination of services to assure continuity of care without duplication of services may be necessary. DSDS staff and the waiver provider will assist participants in the implementation of services authorized or other areas identified within the service plan.
(e) DSDS staff, waiver provider staff, and the participant coordinate the implementation of the service plan, including non-waiver services.
(f) DSDS staff, the participant, and the waiver provider are responsible for implementation and compliance with the service plan. The right of self-determination shall necessitate the individual's participation and approval of the service plan.
(g) Service plans are reviewed by qualified individuals as warranted, but no less than annually.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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. These needs are noted on the Participant Choice Statement in order to document what actions are taken to mitigate any risk problems. During the assessment process, participants are made aware of the need to have in place back-up plans to address contingencies such as emergencies, natural or human-made disasters, failure of the waiver provider staff to show up as scheduled, etc. Types of back-up arrangements that could be utilized are discussed and identified with the participant and documented on the assessment tool, which is a companion document to other service planning documents. These

arrangements could include but are not limited to: awareness of emergency contact number for the waiver provider, contact names/phone numbers of individuals that could be reached 24/7, listing of family members or others that are willing/ready to act as back-up aides or assist participant in various ways, arrangements with someone to check on participants on an at least daily basis, and registration with utility companies to ensure utilities are returned to service quickly, if necessary.

Additionally all qualified providers are subject to universal reporting of abuse, neglect, or exploitation. Missouri statute also includes specific language in certain sections that mandate various entities to report abuse, neglect, or exploitation. When abuse, neglect, or exploitation indicators are noted during assessment/evaluation process, a report is to be made to the DHSS Central Registry Unit as outlined in G-1-b. Response to the report is further defined in G-1-d. Strategies to mitigate identified risk of abuse, neglect, or exploitation to the participant are discussed with the participant by DSDS staff and developed within a protective service plan as outlined in G-1-e.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

A list of eligible providers is reviewed with the participant during the initial service planning process. Participants may choose the provider they want from this list. Participants can also access a MO HealthNet Provider Search function on the DSS/MHD website (www.dss.mo.gov). Participant choice is documented on the Participant Choice Statement by the participant's signature. A copy of the statement documenting participant choice is maintained in the HCBS Web Tool. A list of all qualified providers is available to the participant upon request at reassessment, or any time they request a provider change. New providers are added to the provider list on a continuous and ongoing basis.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Division of Senior and Disability Services (DSDS) staff develop the initial service plan and review the service plan no less than annually. A change to the service plan may be requested by anyone, including the participant, when there is a change in the participant's needs. However all service plan changes are subject to the review and approval of DSDS staff and include discussion with the participant.

Additionally, DSDS staff complete a statistically valid number of record reviews, no less than annually, on an ongoing basis to assure service plans are completed in accordance with waiver policies and procedures. Reports are produced and sent to MO HealthNet Division (MHD) no less than annually, which document the outcome of the reviews. MHD will review the report no less than annually. Supporting documentation will be available to MHD upon request.

In addition to the annual statistically valid sampling review performed by DSDS, MHD also conducts their own review based upon 25 randomly selected participants. The review by staff from MHD ensures individuals receiving waivered services had a service plan in effect for the period of time services were provided. The review process also ensures that the need for services that were provided was documented in the service plan, and that all service needs in the plan were properly authorized.

At any time, MHD may conduct a record review of the service plan by accessing the HCBS Web Tool. However, making the service plan subject to the approval of the state Medicaid agency (MHD) will normally be through reports generated by DSDS to negate the need for redundancy and duplication of efforts related to record reviews.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☑ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

Waiver provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) The Division of Senior and Disability Services (DSDS) staff are responsible for monitoring and assuring the implementation of the service plan.
(b) 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. When services are not initiated within the required time, the provider reports this information to DSDS. In addition to the 10 day follow-up by DSDS the waiver provider is required to monitor, at least monthly, the provision of services to ensure services are being delivered in accordance with the care plan. DSDS staff are to be contacted immediately regarding any critical issues identified during the monitoring. Service plan changes could be initiated as a result of these evaluations of the participant's status and service plan. Participants are advised of their right of provider choice, if service provision is an issue with the participant.
(c) At least annually, direct contact is made with the participant. Information discussed and provided to participants annually during the assessment and reassessment process includes the following statement: "I agree to notify DSDS staff (REV Team) at _____ if I have concerns with my services." Once this is discussed with the participants and or their guardian, they acknowledge they understand by signing the form.
No less than annually DSDS conducts case record reviews on a statistically valid sample of participants to identify any issues related to the waiver assurances and sub-assurances including level of care, plan of care (including non-waiver referrals and supports), health and welfare, and provider choice.
No less than annually DSDS will provide the Medicaid agency with reports related to the performance measures as specified in the quality section of Appendix D.
The effectiveness of the back-up plan is reviewed with the participant as needed but no less than annually.

The following requirements are applicable to all ADW participants regardless of the date of the last reassessment. The provider's aides are required to report to their supervisor when the care needs of the participant changes. The providers, in turn, are required to report to DSDS anytime there is a change in the participant's needs. DSDS then has

further discussion with the participant to discuss any potential care plan changes. Also, when there is a provider nurse visit, the nurse goes over the care plan to assure the adequacy of the care plan. Pursuant to state statute, at any time the provider owner, operator, or any employee is aware of, or suspects any abuse, neglect, or exploitation has occurred, the provider is required to immediately report that information to the Department of Health and Senior Services' Central Registry Unit (CRU) for further investigation. In addition, DSDS conducts, no less than annually, case record reviews on a statistically valid sample of waiver participants. This includes reviewing the care plan and all supporting documentation in that participant's case record.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of service plans that identify and address the participant's assessed needs. Numerator= Number of service plans reviewed that address the participant's assessed needs. Denominator= Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

Responsible Party for	Frequency of data	Sampling Approach

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percent of service plans indicating all risk factors have been assessed and addressed in the service plan. Numerator = Number of service plans indicating all risk factors have been assessed and addressed in the service plan. Denominator = Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of service plans indicating all personal goals have been assessed and addressed in the service plan. Numerator = Number of service plans indicating all assessed personal goals have been assessed and addressed. Denominator = Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participant files that indicated the participant and/or responsible party was involved in the service plan development. Numerator: Number of participant files that indicated the participant and/or responsible party was involved in the service plan development. Denominator: Number of participant files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participant service plans that were reviewed within 365 days of the most recent service plan. Numerator = Number of participant service plans that were reviewed within 365 days of the most recent service plan. Denominator = Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participant service plans that were updated when the participant's needs changed. Numerator = Number of participant service plans that were updated when the participant's needs changed. Denominator = Number of service plans requiring revision due to an identified change in need.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants that received each service type authorized in their service plan. Numerator: Number of participants that received each service type authorized in their service plan. Denominator: Number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 50 randomly selected records
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received services for the duration specified in their approved service plan. Numerator: Number of participants who received services for the duration specified in their approved service plan. Denominator: Number of participant service plans reviewed.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 50 randomly selected records
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participant service plans with the participant's signature that specifies choice was offered among waiver services and providers. Numerator = Number of participant service plans with the participant's signature that specifies choice was offered among waiver services and providers. Denominator = Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participant service plans with the participant's signature that specifies choice was offered between institutional care and waiver services. Numerator = Number of participant service plans with the participant's signature that specifies choice was offered between institutional care and waiver services. Denominator = Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

When an error is discovered during a Division of Senior and Disability Services (DSDS) case record review or one is identified in a DSDS report, a DSDS supervisor reviews the error, and works with the appropriate worker to address the error. General methods of remediation may include: service plan revisions, re-training staff, discussions during area and regional meetings and/or change in DSDS policy or procedure.

If it is determined during the case record review waiver services were not provided in accordance with the service plan, DSDS will request information from the provider as to why the services were not provided as specified in the care plan. General methods of remediation may include: provider training, service plan changes and/or a formal letter to the provider requiring a corrective action plan to ensure services are provided in accordance with the care plan.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- Yes. The State requests that this waiver be considered for Independence Plus designation.
- No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

During the assessment/service planning process, potential waiver participants are advised of their right to appeal and participate in a fair hearing when they are adversely impacted, i.e., denied services, feel their freedom of choice in selecting Home and Community Based Services (HCBS) vs. institutional services or provider(s) is denied, he/she is in disagreement with the level of care determination or service planning results, and/or is in disagreement when services are reduced, suspended or terminated. This information/process is discussed with the participant by the Division of Senior and Disability Services (DSDS). This information is also provided in writing to the participant when services are recommended; the participant will be requested to sign an acknowledgement that the appeal/fair hearing process has been explained to him/her.

In the event of an adverse action as described above, the waiver participant is advised verbally of the proposed action by DSDS. The participant also receives a written adverse action notice that specifies the proposed adverse action, his/her right to appeal the action and to request a fair hearing on the action, and confirmation that the request for a hearing must be made within 90 days of receipt of the adverse action notice. The written adverse action notice also advises the participant if a hearing is requested within 10 calendar days of receipt of the adverse action notice, services will continue as authorized at that time pending the hearing decision.

Participants can appeal the adverse action and request a hearing in writing, or may verbally contact DSDS, who will assist in the completion of the request for hearing form and submit it to the Department of Social Services (DSS), Division of Legal Services (DLS) for the participant.

Copies of adverse action notices and requests for hearing are maintained in the HCBS Web Tool.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

   - (●) **No. This Appendix does not apply**
   - ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved

when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical incidents include physical abuse, sexual abuse, emotional abuse, exploitation, misappropriation of funds/property, neglect (by self, or by others). Missouri statutes states any person having reasonable cause to suspect that an eligible adult is experiencing abuse or neglect and is in need of protective services shall report such information to the Department of Health and Senior Services (DHSS). Missouri statutes requires any adult day care

worker; chiropractor; Christian Science practitioner; coroner; dentist; embalmer; employee of the Departments of Social Services, Mental Health, or Health and Senior Services; employee of a local Area Agency on Aging or an organized Area Agency on Aging program; emergency medical technician; firefighter; first responder; funeral director; home health agency; home health agency employee; hospital and clinic personnel engaged in the care or treatment of others; in-home services owner or provider, in-home services operator or employee; law enforcement officer; long-term care facility administrator or employee; medical examiner; medical resident or intern; mental health professional; minister; nurse; nurse practitioner; optometrist; other health practitioner; peace officer; pharmacist; physical therapist; physician; physician's assistant; podiatrist; probation or parole officer; psychologist; consumer-directed services provider (this included Independent Living Waiver providers); personal care attendant; social worker or other person with the responsibility for the care of an eligible adult who has reasonable cause to suspect that the eligible adult has been subjected to abuse or neglect or observes the eligible adult being subjected to conditions or circumstances which would reasonably result in abuse or neglect. Mandated reporters who fail to report or cause a report to be made to DHSS immediately after the act of abuse or neglect are guilty of a Class A misdemeanor (198.070, 192.2475, and 208.912, RSMo). The methods of reporting include calling DHSS staff or the Central Registry Unit 800# (this number is promoted on DHSS public information, brochure, posters, and website), written correspondence with DHSS or through the 'Ask Us' function on DHSS' website. All reports are entered into the Mo Case Compass system, regardless of the method utilized to report, in order to track all reports.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DSDS and waiver providers provide participants with information (verbally and in written format) about reporting policy and procedures for incidents at the time of enrollment, annually, and any time the waiver participant perceives that his/her rights and/or responsibilities have been violated. DHSS staff, DSDS, etc., instruct the waiver participant, legally responsible parties, and any informal caregivers about the types of critical incidents and all the methods/options for reporting incidents of abuse, neglect, or exploitation to DHSS. The Participant Choice Statement document the participants sign includes the sentence, "I understand I can call the toll-free hotline at 1-800-392-0210 to report abuse, neglect, or exploitation." This document is gone over thoroughly with participants at the initial authorization of Home and Community Based Services and at least annually thereafter.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Department of Health and Senior Services (DHSS) is the mandated adult protective services agency in Missouri. Statutes 192.2415, 192.2420, and 192.2425, RSMo defines the investigatory authority of DHSS as limited to eligible adults with a protective service need. DHSS/DSDS staff shall investigate and offer protective services to all eligible adults when deemed appropriate. This shall include: 1) adults age 60 years or older who are unable to protect their own interests or adequately perform or obtain services which are necessary to meet their essential human needs; and 2) adults with disabilities between the ages of 18 and 59 who are unable to protect their own interests or adequately perform or obtain services which are necessary to meet their essential human needs. Reports may be received that would not fall within the scope of DHSS' authority but may be appropriately referred to another agency for assistance. All reports are registered by DSDS Home and Community Services or Central Registry Unit (CRU) staff into the states reporting data base system, Mo CaseCompass. The following is applicable to waiver participants receiving services in their own home: Preliminary classification of reports is based on information received from the reporter at the point of intake. Classification is based on the level of harm or risk to the eligible adult, combined with the reported need to gather evidence. Class I reports contain allegations, which if true, present either an imminent danger to the health, safety, or welfare of an eligible adult or a substantial probability that death or serious physical harm will result. Class I reports involve situations of a crisis or acute nature which are currently occurring and require immediate intervention and/or investigation to gather critical evidence. (Reporters are directed to contact the local law enforcement agency on reports involving allegations of homicide or suicidal threats). Class II reports contain allegations of some form of abuse, neglect, or exploitation of an eligible adult but do not allege or imply a substantial probability of immediate harm or danger, but may present a substantial risk to the health, safety, and welfare of an eligible adult. Situations described in a Class II report do not require an immediate response, but must be initiated within set timeframes. DHSS staff are responsible for completing a prompt and thorough investigation of all allegations. Mo CaseCompass develops a baseline investigation plan to which the investigator can add additional activities/tasks as appropriate to each case and is completed in the Mo CaseCompass system. Depending on the report, the investigation plan may include a combination of Activities/Tasks to address: 1) Review of the report and

conducting background checks of the subjects of the report. 2) Development of an investigative plan, outlining the actions to be taken in accordance with the reported information. The investigative plan will include the assessed need to involve medical professionals; the order of the interviews to be conducted, i.e., reporter, eligible adult, witnesses and the alleged perpetrator; determination of which records or documents need to be obtained to (dis)prove the allegations in the report; evidence suggested in the report to be immediately obtainable which will assist in (dis) proving the allegations and determination of which agency or entity (if any) that needs to be contacted to co-investigate or provide support. 3) Conduct a thorough investigation obtaining all information necessary to determine whether the alleged abuse, neglect or exploitation actually occurred (or is occurring). The information is gathered and memorialized through documentation to properly preserve the evidence. 4) Evaluation, analysis, organizing and reviewing the information to determine if legal intervention or protective services is warranted. 5) Complete a summary and determine the investigative conclusion according to the information obtained during the investigation. This will include recording all contacts and activities related to the investigation in the case record. 6) Policy requires investigations are conducted and completed and findings/results entered into the Mo CaseCompass system within a sixty (60) day period. If the investigation cannot be completed within sixty (60) days, DSDS staff request an extension from their supervisor identifying the extenuating circumstances. All reports are entered and routed immediately in Case Compass
In response to Class I reports, a face-to-face must be made as soon as necessary or possible within the 24 hours following receipt of a report to ensure the safety and well-being of an eligible adult. Investigations of Class II reports shall be initiated within a period not to exceed 48 hours after receipt of the report. Investigators shall conduct a face-to-face interview as soon as possible within a period not to exceed seven (7) calendar days from the receipt of the report. A waiver participant for whom an investigation is being conducted is involved in the investigation and the subsequent intervention process or plan on an ongoing basis. Unless otherwise stated in state statutes; specifically, 192.2435, 192.2500, and 192.2505, RSMo DHSS is prohibited from disclosing the investigative results/reports. During the initial visit all DSDS participants receive a notice regarding 42 CFR 160-164. This informs the participant that they may inspect and receive a copy of their information which could include a copy of their abuse, neglect, exploitation investigation report, if applicable.

DSDS does provide report information to the participant, upon request. The participant also may request a copy of their Adult Protective Services (APS) case record at the conclusion of an investigation. In those situations, a letter is sent within three (3) working days of the request notifying the participant of the receipt of their request. The case will be sent within forty-five (45) days of this notification letter.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Division of Senior and Disability Services (DSDS) is responsible for overseeing the operation of the incident management system. DSDS supervisors are required to complete a first review on all reports, as well as a full case review on all reports with a finding of reason to believe; suspicious death reports; cases found reason to believe that would be appropriate for review for potential Employee Disqualification List (EDL) referral; reports completed by any probationary Worker; and, any report deemed necessary by a supervisor or division management. In addition, the supervisor shall periodically review all other reports. The supervisory review determines if the staff person conducting the investigation has followed policy and procedure during the investigation, has communicated with all the necessary parties, and has documented the investigation correctly. This oversight is conducted on an ongoing basis. The supervisor, in an effort to assist in ensuring the on-going quality of the investigations, will conference with staff on reports, read on-going records, and go on interviews with the investigator. This oversight is also conducted on an ongoing basis. The Mo CaseCompass system is utilized to document the information obtained during the investigation and track occurrence/reoccurrence of ANE by eligible adult and alleged perpetrator. This system is accessible to all investigating staff and can be utilized in the investigation process to track past allegations were handled. DSDS is mandated to obtain or coordinate protective services for eligible participants to help prevent future reports by reducing the cause of the abuse, neglect, or exploitation through a variety of activities: financial/economic interventions, education, local community supports, in-home or consumer-directed services, use of the resources of other agencies/entities, and follow-up contact with eligible adults that have an open protective service case. Waiver participants that have been placed under 'protective service' status are identified along with the level of protective service needed. These levels are: Indicative of a minimal but consistent need for protective intervention with the intent to reduce injury/harm by increasing support system and regular contacts to be made as needed to the support system and a minimum of one home visit every six months, or- Indicative of a moderate need for protective intervention with contacts to occur on a regular basis averaging at least twice per month and a minimum of one home visit every six months, or- Indicative of intense need for protective intervention with contacts to occur with and/or on the behalf of the participant weekly and a home visit monthly.

Participant information is collected and compiled in the state reporting data base, Mo CaseCompass. The methods of reporting include calling DSDS staff or the Central Registry Unit 800# (this number is promoted on DHSS public information, brochure, posters and website), written correspondence with DHSS or through the 'Ask Us' function on DHSS' website. All reports are registered in the Mo CaseCompass system, regardless of the method utilized to report, in order to track all reports. Information gathered on abuse, neglect, and exploitation are used to prevent reoccurrence through education and changes in policy and procedures including but not limited to staff and provider training and public awareness.
DSDS provides summary reports to the Medicaid Agency no less than annually.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Health and Senior Services (DHSS) considers manual hold techniques and mechanical restraints to be a physical restraint. Manual hold techniques and mechanical restraints are designed to physically hold, immobilize, and reduce the ability of an individual to move his or her arms, legs, body or head freely- therefore they should be considered to be a physical restraint.

DHSS instructs inspectors that non-physical intervention techniques should always be the first course of action to assist in the de-escalation of behaviors, and potential interventions should be clearly delineated and easily understood by anyone who reads the participant's care plan. Only as a last resort, when a participant has unanticipated violent or aggressive behavior that places him/her or others in imminent danger, does the program have the ability to contact the physician related to this change in status and to obtain an order for physical restraints in order to assist the participant from harming his/herself. Physical restraints may not be used for the purpose of discipline or convenience.

According to state regulation, all HCBS providers and staff are required to adhere to a code of ethics which includes prohibition of committing any act of abuse, neglect, or exploitation. In addition, all HCBS providers are required to report any known or suspected abuse, neglect, or exploitation of a participant to the state's Central Registry Unit.

State regulation requires all Adult Day Care programs to ensure that each participant of the adult day care program be assured of the following rights- To be free of restraint, unless under physicians order as indicated in the individual's care plan. The Division of Regulation and Licensure does not define the term short term, however, 19 CSR 30-90 states that all participants have the right to be free of restraints unless under a physician's order indicated in the individuals care plan. Therefore, short term would be individualized based upon the participant's person centered care plan.

Program Inspectors have been trained in the identification of physical, chemical, and mechanical restraints. State laws, regulations, and policies referenced are available to CMS upon request through the Medicaid Agency or the Operating Agency.

The participant has the right to be free from any physical or chemical restraint except as follows:
(A) When used to treat a specified medical symptom as a part of a total program of care to assist the resident to attain or maintain the highest practicable level of physical, mental, or psychosocial well-being. The use of restraints must be authorized in writing by a physician for a specified period of time; or
(B) When necessary in an emergency to protect the participant from injury to himself or herself or to others, in which case restraints may be authorized by professional personnel so designated by the program. The action taken shall be reported immediately to the participant's physician and an order obtained which shall include the reason for the restraint, when the restraint may be removed, the type of restraint, and any other actions required. When restraints are indicated, only devices that are the least restrictive for the participant and consistent with the participant's total plan of care may be used. Each participant has the right to be free from involuntary seclusion.

Observation, interview, and record review during inspections and complaint investigations to determine use and appropriateness of the use. Determine if the restraint was used only after a complete assessment and care planning. Ensure that only the least restrictive restraint has been used and appropriate for the individual participant to attain or maintain his or her highest practicable physical and psychosocial well-being. Monitor to ensure the program continues to assess the care plan and restraint use on an ongoing basis. Documentation of the use of restrictive interventions must be recorded in the participant record by the facility director or their designee.

The Section for Long Term Care Regulation (SCLR) utilizes the interpretive guidance provided by the State Operation Manual (SOM), from the Centers for Medicare and Medicaid Services (CMS) for Skilled Nursing Facilities as a guide to ensure a proper standard of practice is followed by providers. This guidance is commonly referred to as F221 and F222. Any restraint must be authorized by the participant/legal guardian and their physician and must be determined to part of the overall plan of care and monitoring.

Determine if the program follows a systematic process of evaluation and care planning prior to using restraints. Since continued restraint use is associated with a potential decline in functioning if the risk is not addressed, determine if the interdisciplinary team addressed the risk of decline at the time restraint use was initiated and that the care plan reflected measures to minimize a decline. Also determine if the plan of care was consistently implemented. Determine whether the decline can be attributed to a disease progression and/or inappropriate use of restraints.

The adult day care provider would be required to provide evidence of a systematic process of evaluation and care planning prior to using restraints. The written individual plan of care for each participant is to be designed to maintain the participant at, or to restore to, optimal capability for self-care. The plan is based on a functional assessment and information obtained from the participant, participant’s family, physician and the person or agency referring the participant. The plan is to address the participant’s physical, social and psychological needs, goals and means of accomplishing goals to the degree that the program is designed and the staff are qualified to meet these goals. The plan identifies the positions of persons responsible for specific individualized activities provided for the participant that are not documented by the regularly scheduled plan of activities for the program. The plan of care is revised as frequently as warranted by the participant’s condition, but is minimally reviewed at least every six (6) months and updated as necessary.

ADC must have staff trained and who are able to provide the appropriate care and services required to assist the participant in accomplishing their goals and carrying out the plan of care. Direct care paid staff shall be at least eighteen (18) years of age and qualified by education, training, experience or demonstrated competence in order to perform their duties. All medications are required to be received, controlled and administered by a licensed practical nurse or a registered nurse.

Program Inspectors are employees of the Department of Health and Senior Services who are trained to complete inspections and complaint investigations in Residential Care Facilities, Assisted Living Facilities, and Adult Day Care Programs.

All adult day care staff, including non-direct care, direct care and volunteers are to be provided training related to all policies and procedures prior to performing job responsibilities. The orientation is to be an in depth training to enable staff to perform their assigned job responsibilities and meet the individual needs of participants.

Staff are not allowed to perform job functions for which they are not trained and/or have the certification or license to provide. Any restraint must be applied by staff trained in its safe application, and must be authorized by a physician prior to its application and an order obtained containing specific criteria including the reason for the restraint, the type of restraint, when it may be removed and any other actions required. When the physician has determined a restraint is necessary, only devices that are the least restrictive for the participant and consistent with the participant's total treatment program shall be used. It is never appropriate for the participant's physician orders to contain “standing” or PRN (as needed) orders for the use of any type of restraint. This criteria is the same for any restraint- whether physical, chemical, mechanical or “restrictive intervention.”

Nonphysical interventions are the first choice as an intervention when someone is beginning to lose control of his or her actions or behaviors. Early intervention crisis prevention techniques must be the first effort used to de-escalate conflict when possible. These techniques must be taught to all staff members, prior to their being placed in a situation where they must be used. ADC providers must ensure they are using the safest possible interventions for all participants.

At least quarterly, or as needed based on participant's needs, in-service training is to be provided to staff, as appropriate to their job function or participant care needs. At a minimum, in-service training is to address:
(A) Participant care needs, both general and individualized;
(B) Participants rights;
(C) Program policies; and
(D) Specialized care needs, such as Alzheimer’s disease or related dementias, appropriate to the needs of participants, as follows:
1. For employees providing direct care to persons with Alzheimer’s disease or related dementia, the training shall include:
A. An overview of Alzheimer’s disease and related dementia;
B. Communicating with persons with dementia;
C. Behavior management;
D. Promoting independence in activities of daily living;
E. Understanding and dealing with family issues;
2. For employees who do not provide direct care for, but may have daily contact with, persons with Alzheimer’s disease or related dementia, the training shall include.
A. An overview of dementia; and
B. Communicating with persons with dementia."

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The operating agency conducts case record reviews of Aged and Disabled Waiver participants. These reviews include data regarding abuse, neglect, and exploitation. Additionally, the operating agency reports on use of restraints in Adult Day Care programs in cooperation with Division of Regulation and Licensure (DRL) the results of the case record reviews are reported to the State Medicaid Agency at least annually.
The Department of Health and Senior Services (DHSS), Division of Regulation and Licensure (DRL) is responsible for oversight related to statutory and regulatory requirements regarding Adult Day Care programs. During relicensure DRL staff shall document the inspection process using the Inspector Notes Worksheet- Adult Day Care. There is no specific form for non-ADC providers to complete. However, Aged and Disabled Waiver providers are held to all standards outlined in regulation, statute, and provider contracts through Missouri Medicaid Audit and Compliance (MMAC).

State regulations requires all Adult Day Care programs to ensure that each participant of the adult day care program be assured of the following rights: To be free of restraint, unless under physicians order as

indicated in the individual's care plan.

The State Medicaid Agency has access to ASPEN, the federal database that houses all inspection/survey activity in the state for all levels of long term care and adult day care programs. They are able to review Statements of Deficiency (SOD)'s produced by SLCR at any time. The State Medicaid Agency is also copied on all letters/licenses for new/existing/closed providers, and also are copied on all letters in regards to license denial or revocation.

Observation, interview and record review during inspections and complaint investigations to determine use and appropriateness of the use. Determine if the restraint was used only after a complete assessment and care planning. Ensure that only the least restrictive restraint has been used and appropriate for the individual participant to attain or maintain his or her highest practicable physical and psychosocial well-being. Monitor to ensure the program continues to assess and care plan the restraint use on an ongoing basis.

Section for Long Term Care Regulation (SLCR) prepares citation reports from ASPEN on an at least yearly basis to identify what citations are most frequently cited and uses the reports to provide training to adult day care providers on frequent citations.

Full licensure inspections are completed at least upon initial licensing, every two years prior to the expiration of the program license and then as needed for onsite revisits, complaint investigations, participant capacity changes, etc.

DHSS, the state licensing agency for Adult Day Care program, utilizes ASPEN, the federal database required by the Centers for Medicare and Medicaid Services (CMS) for Skilled Nursing Facility survey tracking, to also track their state licensed processes. Each inspection and any corresponding citations are entered into ASPEN. From this database, reports are run to determine the frequency of citations so that reports can be provided to the Adult Day Care providers on frequently cited citations and trends, and training programs can be tailored to address a particular area of concern. Reports can be run specifically on the incidence of restraints being cited.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The waiver manual states that a restrictive intervention is "An action or procedure that limits an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights."
DHSS does not utilize the phrase "restrictive interventions" in licensing regulations. However, each

piece of the definition is addressed in the licensure regulations. DHSS views limiting an individual's movement to be a physical restraint. Restricting an individual's access to other individuals, locations, or activities is considered to be seclusion. Participant rights may not be restricted by the program, and they include the following protections from these events. Each participant of the adult day care program is assured of the following rights:
(A) To be treated as an adult, with respect and dignity regardless of race, color, sex or creed;
(B) To participate in a program of services and activities which promotes positive attitudes regarding one's usefulness and capabilities;
(C) To participate in a program of services designed to encourage learning, growth, and awareness of constructive ways to develop one's interests and talents;
(D) To maintain one's independence to the extent that conditions and circumstances permit, and to be involved in a program of services designed to promote personal independence;
(E) To be encouraged to attain self-determination within the adult day care setting, including the opportunity to participate in developing one's plan for services;
(F) To decide whether or not to participate in any given activity and to be involved in the extent possible in program planning and operation;
(G) To be cared for in an atmosphere of sincere interest and concern in which needed support and services are provided;
(H) To have access to a telephone to make or receive calls, unless necessary restrictions are indicated in the individual's care plan;
(I) To have privacy and confidentiality;
(J) To be free of mental or physical abuse;
(K) To be free to choose whether or not to perform services for the program;
(L) To be free of restraint, unless under physician's order as indicated in the individual's care plan; and
(M) To be free of interference, coercion, discrimination or reprisal.
DHSS monitors ADC providers during onsite inspections to ensure compliance with all ADC regulations, including "restrictive interventions".

State regulations requires all Adult Day Care programs to ensure that each participant of the adult day care program be assured of the following rights - to be free of restraint, unless under physicians order as indicated in the individual's care plan.
Program Inspectors have been trained in the identification of physical, chemical, and mechanical restraints.
State laws, regulations, and policies referenced in the specifications are available to CMS upon request through the Medicaid Agency or the Operating Agency.
The participant has the right to be free from any physical or chemical restraint except as follows:
(A) When used to treat a specified medical symptom as a part of a total program of care to assist the participant to attain or maintain the highest practicable level of physical, mental, or psychosocial well-being. The use of restraints must be authorized in writing by a physician for a specified period of time; or
(B) When necessary in an emergency to protect the participant from injury to himself or herself or to others, in which case restraints may be authorized by professional personnel so designated by the program. The action taken shall be reported immediately to the participant's physician and an order obtained which shall include the reason for the restraint, when the restraint may be removed, the type of restraint, and any other actions required. When restraints are indicated, only devices that are the least restrictive for the participant and consistent with the participant's total plan of care may be used. Each participant has the right to be free from involuntary seclusion.
Observation, interview, and record review during inspections and complaint investigations to determine use and appropriateness of the use. Determine if the restraint was used only after a complete assessment and care planning. Ensure that only the least restrictive restraint has been used and appropriate for the individual participant to attain or maintain his or her highest practicable physical and psychosocial well-being. Monitor to ensure the program continues to assess and care plan the restraint use on an ongoing basis.
The Section for Long Term Care Regulation (SLCR) utilizes the interpretive guidance provided by the State Operation Manual (SOM), from the Centers for Medicare and Medicaid Services (CMS) for Skilled Nursing Facilities as a guide to ensure a proper standard of practice is followed by providers. This guidance is commonly referred to as F221 and F222. Any restraint must be authorized by the participant/legal guardian and their physician and must be determined to part of the overall plan of care and monitoring. Documentation of the use of restrictive interventions must be recorded in the participant's record by the program director or their designee.
Determine if the program follows a systematic process of evaluation and care planning prior to using

restraints. Since continued restraint use is associated with a potential decline in functioning if the risk is not addressed, determine if the interdisciplinary team addressed the risk of decline at the time restraint use was initiated and that the care plan reflected measures to minimize a decline. Also determine if the plan of care was consistently implemented. Determine whether the decline can be attributed to a disease progression and/or inappropriate use of restraints.
The adult day care provider would be required to provide evidence of a systematic process of evaluation and care planning prior to using restraints. The written individual plan of care for each participant is to be designed to maintain the participant at, or to restore to, optimal capability for self-care. The plan is based on a functional assessment and information obtained from the participant, participant's family, physician and the person or agency referring the participant. The plan is to address the participant's physical, social and psychological needs, goals and means of accomplishing goals to the degree that the program is designed and the staff are qualified to meet these goals. The plan identifies the positions of persons responsible for specific individualized activities provided for the participant that are not documented by the regularly scheduled plan of activities for the program. The plan of care is revised as frequently as warranted by the participant's condition, but is minimally reviewed at least every six (6) months and updated as necessary.
The ADC must have staff trained and who are able to provide the appropriate care and services required to assist the participant in accomplishing their goals and carrying out the plan of care. Direct care paid staff shall be at least eighteen (18) years of age and qualified by education, training, experience or demonstrated competence in order to perform their duties. All medications are required to be received, controlled and administered by a licensed practical nurse or a registered nurse.
Program Inspectors are employees of the Department of Health and Senior Services who are trained to complete inspections and complaint investigations in Residential Care Facilities, Assisted Living Facilities, and Adult Day Care Programs.
DHSS considers manual hold techniques and mechanical restraints to be a physical restraint. Manual hold techniques and mechanical restraints are designed to physically hold, immobilize and reduce the ability of an individual to move his or her arms, legs, body or head freely- therefore they should be considered to be a physical restraint.
DHSS instructs inspectors that non-physical intervention techniques should always be the first course of action to assist in the de-escalation of behaviors, and potential interventions should be clearly delineated and easily understood by anyone who reads the participant's care plan. Only as a last resort, when a resident has unanticipated violent or aggressive behavior that places him/her or others in imminent danger, does the program have the ability to contact the physician related to this change in status and to obtain an order for physical restraints in order to assist the resident from harming his/herself. Physical restraints may not be used for the purpose of discipline or convenience.

All adult day care staff, including non-direct care, direct care and volunteers are to be provided training related to all policies and procedures prior to performing job responsibilities. The orientation is to be an in depth training to enable staff to perform their assigned job responsibilities and meet the individual needs of participants.
Staff are not allowed to perform job functions for which they are not trained and/or have the certification or license to provide. Any restraint must be applied by staff trained in its safe application, and must be authorized by a physician prior to its application and an order obtained containing specific criteria including the reason for the restraint, the type of restraint, when it may be removed and any other actions required. When the physician has determined a restraint is necessary, only devices that are the least restrictive for the participant and consistent with the participant's total treatment program shall be used. It is never appropriate for the participant's physician orders to contain "standing" or PRN (as needed) orders for the use of any type of restraint. This criteria is the same for any restraint- whether physical, chemical, mechanical or "restrictive intervention."
The State recognizes that this information is largely a restatement of the State's approach to physical or chemical restraint. The State is taking steps to improve provider knowledge and compliance in this area through the Statewide HCBS Settings Transition Plan, which involves a process to analyze and address updating of state regulations specific to this topic. Specifically, the state conducted public meetings to receive stakeholder input to develop a regulation crosswalk. This regulation crosswalk is a guide for the state in what changes will be necessary and the applicable timeline for state regulation changes specific to restrictive interventions and all other areas of the HCBS Settings Rule.
Since participants are encouraged to attain self-determination within the adult day care program, including the opportunity to participate in developing one's plan for services; and since they have the right to decide whether or not to participate in any given activity and to be involved in the extent possible in program planning and operation, providers must ensure participants are not being secluded from other

individuals or activities.
DHSS documents findings on Inspector Notes Worksheet – Adult Day Care. Negative findings will be additionally documented in ASPEN, the federal database required by the Centers for Medicare and Medicaid Services (CMS) for Skilled Nursing Facility survey tracking- to also track citations and generate report findings (referred to as Statements of Deficiency).
At least quarterly, or as needed based on participant's needs, in-service training is to be provided to staff, as appropriate to their job function or participant care needs. At a minimum, in-service training is to address:
(A) Participant care needs, both general and individualized;
(B) Participant's rights;
(C) Program policies; and
(D) Specialized care needs, such as Alzheimer's disease or related dementias, appropriate to the needs of participants, as follows:
1. For employees providing direct care to persons with Alzheimer's disease or related dementia, the training shall include:
A. An overview of Alzheimer's disease and related dementia;
B. Communicating with persons with dementia;
C. Behavior management;
D. Promoting independence in activities of daily living;
E. Understanding and dealing with family issues; and
2. For employees who do not provide direct care for, but may have daily contact with, persons with Alzheimer's disease or related dementia, the training shall include.
A. An overview of dementia; and
B. Communicating with persons with dementia.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Health and Senior Services (DHSS), the state licensing agency for Adult Day Care programs, is responsible for overseeing ADC programs and ensuring that regulations pertaining to restraint, seclusion, and participant rights are adhered to and that participants are safe in their environment. DHSS complete onsite inspections and through observation, interview and record review ensure programs are following the regulations and providing services in accordance with the regulations.

DHSS utilizes ASPEN, the federal database required by the Centers for Medicare and Medicaid Services (CMS) for Skilled Nursing Facility survey tracking, to also track their state licensed processes. Each inspection and any corresponding citations are entered into ASPEN. From this database, reports are run to determine the frequency of citations so that reports can be provided to the ADC providers on frequently cited citations and trends, and training programs can be tailored to address a particular area of concern. Reports can be run specifically on the incidence of restraints, and violations of resident rights being cited.

Additionally, DHSS utilizes ACTS, the federal database required by the Centers for Medicare and Medicaid Services (CMS) for Skilled Nursing Facility complaint report tracking, to collect complaint allegations and to compile findings from investigations. DHSS is able to monitor complaints and corresponding statements of deficiency through ACTS and ASPEN in order to monitor current trends in citations- so that provider groups and DHSS can target industry training to ensure better understanding of regulations and compliance.

State regulations requires all Adult Day Care programs to ensure that each participant of the adult day care program be assured of the following rights: To be free of restraint, unless under physicians order as indicated in the individual's care plan.

The State Medicaid Agency has access to ASPEN, the federal database that houses all inspection/survey activity in the state for all levels of long term care and adult day care programs. They are able to review Statements of Deficiency (SOD)'s produced by SLCR at any time. MHD is also copied on all letters/licenses for new/existing/closed providers, and also are copied on all letters in regards to license denial or revocation.

Observation, interview and record review during inspections and complaint investigations to determine

use and appropriateness of the use. Determine if the restraint was used only after a complete assessment and care planning. Ensure that only the least restrictive restraint has been used and appropriate for the individual participant to attain or maintain his or her highest practicable physical and psychosocial well-being. Monitor to ensure the program continues to assess and care plan the restraint use on an ongoing basis.

Section for Long Term Care Regulation (SLCR) prepares citation reports from ASPEN on an at least yearly basis to identify what citations are most frequently cited and uses the reports to provide training to adult day care providers on frequent citations.

Full licensure inspections are completed at least upon initial licensing, every two years prior to the expiration of the program license and then as needed for onsite revisits, complaint investigations, participant capacity changes, etc.

DHSS, the state licensing agency for Adult Day Care program, utilizes ASPEN, the federal database required by the Centers for Medicare and Medicaid Services (CMS) for Skilled Nursing Facility survey tracking, to also track their state licensed processes. Each inspection and any corresponding citations are entered into ASPEN. From this database, reports are run to determine the frequency of citations so that reports can be provided to the ADC providers on frequently cited citations and trends, and training programs can be tailored to address a particular area of concern. Reports can be run specifically on the incidence of restraints being cited.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

According to state regulation, all HCBS providers & staff are required to adhere to a code of ethics which includes prohibition of committing any act of abuse, neglect, or exploitation. In addition, all HCBS providers are required to report any known or suspected abuse, neglect, or exploitation of a participant to the state's Central Registry Unit.
The waiver manual identifies seclusion as the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving. DHSS does not utilize the word seclusion in the licensing regulations for ADC programs; however, participant rights regulations speak to the different components of the definition. Missouri uses the definition & concepts outlined in the State Operations Manual, Appendix PP from CMS for involuntary seclusion as a standard of practice for providers. Involuntary seclusion is the separation of an individual from others or confinement to a room (with or without others against the individual's will, or the will of their legal representative.) Emergency or short term monitored separation from other individuals would not be considered involuntary seclusion & may be permitted if used for a limited period of time as a

therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the individual's needs.
The Division of Regulation & Licensure does not define the term short term; however, regulation states that all participants have the right to be free of restraints unless under a physician's order indicated in the individual's care plan. Therefore, short term would be individualized based upon the participant's person centered care plan.
Restricting an individual's access to other individual's, locations, or activities can be viewed as a violation of participant rights, as a restraint, or in some instances abuse.
Individuals should be able to move freely throughout the program, in accordance with their individual needs & preferences. In accordance with CMS guidance, if an individual receives emergency short-term monitored separation due to temporary behavioral symptoms (such as brief catastrophic reactions or combative or aggressive behaviors which pose a threat to the individual or others), this would not be considered involuntary seclusion as long as this is the least restrictive approach for the minimum amount of time, & is being done according to participant needs and not for staff convenience
Participant rights may not be restricted by the program and they include the following protections from these events. Each participant of the ADC program, in addition to other rights, is assured of the following:
To be treated as an adult, with respect and dignity regardless of race, color, sex or creed;
To be free of restraint, unless under physician's order as indicated in the individual's care plan; and
To be free of interference, coercion, discrimination or reprisal
DHSS monitors ADC providers during onsite inspections to ensure compliance with all ADC regulations, including restraints, seclusion, and restrictive interventions
State regulations require all ADC programs to ensure that each participant of the ADC program be assured of the following rights- To be free of restraint, unless under physicians order as indicated in the individual's care plan
Program Inspectors have been trained in the identification of physical, chemical, and mechanical restraints. State laws, regulations, and policies referenced in the specifications are available to CMS upon request through the Medicaid Agency or the Operating Agency.
The participant has the right to be free from any physical, chemical, and mechanical restraint except as follows:
(A) When used to treat a specified medical symptom as a part of a total program of care to assist the participant to attain or maintain the highest practicable level of physical, mental, or psychosocial well-being. The use of restraints must be authorized in writing by a physician for a specified period of time; or
(B) When necessary in an emergency to protect the participant from injury to himself or herself or to others, in which case restraints may be authorized by professional personnel so designated by the program. The action taken shall be reported immediately to the participant's physician and an order obtained which shall include the reason for the restraint, when the restraint may be removed, the type of restraint, and any other actions required. When restraints are indicated, only devices that are the least restrictive for the participant and consistent with the participant's total plan of care may be used. Each participant has the right to be free from involuntary seclusion
Observation, interview, and record review during inspections and complaint investigations to determine use and appropriateness of the use. Determine if the restraint was used only after a complete assessment and care planning. Ensure that only the least restrictive restraint has been used and appropriate for the individual participant to attain or maintain his or her highest practicable physical and psychosocial well-being. Monitor to ensure the program continues to assess and care plan the restraint use on an ongoing basis.
The Section for Long Term Care Regulation (SLCR) utilizes the interpretive guidance provided by the State Operation Manual (SOM), from the Centers for Medicare and Medicaid Services for Skilled Nursing Facilities as a guide to ensure a proper standard of practice is followed by providers. This guidance is commonly referred to as F221 and F222. Any restraint must be authorized by the participant/legal guardian and their physician and must be determined to part of the overall plan of care and monitoring. Documentation of the use of restrictive interventions must be recorded in the participant record by the program director or their designee
Determine if the program follows a systematic process of evaluation and care planning prior to using restraints. Since continued restraint use is associated with a potential decline in functioning if the risk is not addressed, determine if the interdisciplinary team addressed the risk of decline at the time restraint use was initiated and that the care plan reflected measures to minimize a decline. Also determine if the plan of care was consistently implemented. Determine whether the decline can be attributed to a disease progression and/or inappropriate use of restraints
The ADC provider would be required to provide evidence of a systematic process of evaluation and care

planning prior to using restraints. The written individual plan of care for each participant is to be designed to maintain the participant at, or to restore to, optimal capability for self-care. The plan is based on a functional assessment and information obtained from the participant, participant's family, physician and the person or agency referring the participant. The plan is to address the participant's physical, social and psychological needs, goals and means of accomplishing goals to the degree that the program is designed and the staff are qualified to meet these goals. The plan identifies the positions of persons responsible for specific individualized activities provided for the participant that are not documented by the regularly scheduled plan of activities for the program. The plan of care is revised as frequently as warranted by the participant's condition, but is minimally reviewed at least every six (6) months and updated as necessary
ADC must have staff trained and who are able to provide the appropriate care and services required to assist the participant in accomplishing their goals and carrying out the plan of care. Direct care paid staff shall be at least eighteen (18) years of age and qualified by education, training, experience or demonstrated competence in order to perform their duties. All medications are required to be received, controlled and administered by a licensed practical nurse or a registered nurse
Program Inspectors are employees of the Department of Health and Senior Services who are trained to complete inspections and complaint investigations in Residential Care Facilities, Assisted Living Facilities, and ADC Programs
DHSS instructs inspectors that non-physical intervention techniques should always be the first course of action to assist in the de-escalation of behaviors, and potential interventions should be clearly delineated and easily understood by anyone who reads the participant's care plan. Only as a last resort, when a participant has unanticipated violent or aggressive behavior that places him/her or others in imminent danger, does the program have the ability to contact the physician related to this change in status and to obtain an order for a physical restraints in order to assist the participant from harming his/herself. Physical restraints may not be used for the purpose of discipline or convenience
All ADC staff, including non-direct care, direct care, and volunteers are to be provided training related to all policies and procedures prior to performing job responsibilities. The orientation is to be an in depth training to enable staff to perform their assigned job responsibilities and meet the individual needs of participants.
Staff are not allowed to perform job functions for which they are not trained and/or have the certification or license to provide. Any restraint must be applied by staff trained in its safe application, and must be authorized by a physician prior to its application and an order obtained containing specific criteria including the reason for the restraint, the type of restraint, when it may be removed and any other actions required. When the physician has determined a restraint is necessary, only devices that are the least restrictive for the participant and consistent with the participant's total treatment program shall be used. It is never appropriate for the participant's physician orders to contain "standing" or PRN (as needed) orders for the use of any type of restraint. This criteria is the same for any restraint- whether physical, chemical, mechanical or "restrictive intervention".
Since participants are encouraged to attain self-determination within the ADC setting, including the opportunity to participate in developing one's plan for services; and since they have the right to decide whether or not to participate in any given activity and to be involved in the extent possible in program planning and operation, providers must ensure participants are not being secluded from other individuals or activities.
The Department of Health & Senior Services (DHSS), Division of Regulation & Licensure (DRL) is responsible for oversight related to statutory & regulatory requirements regarding ADC facilities. During relicensure DRL staff shall document the inspection process using the Inspector Notes Worksheet – ADC. Negative findings will be additionally documented in ASPEN, the federal database required by CMS for Skilled Nursing Facility survey tracking- to also track citations and generate report findings (referred to as Statements of Deficiency).
There is no specific form for non-ADC providers to complete. However, HCBS providers are held to all standards outlined in regulation, statute & provider contracts through Missouri Medicaid Audit & Compliance (MMAC).
At least quarterly, or as needed based on participant's needs, in-service training is to be provided to staff, as appropriate to their job function or participant care needs.
Although DHSS does not currently utilize the word, "seclusion" in the licensing regulation, DHSS is in the process of drafting regulation changes which do specifically address seclusion. Additionally, the State plans to analyze this topic further as the State proceeds with the Statewide HCBS Settings Transition Plan.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Health and Senior Services (DHSS), the state licensing agency for Adult Day Care programs, is responsible for overseeing ADC programs and ensuring that regulations pertaining to restraint, seclusion, and participant rights are adhered to and those participants are safe in their environment. DHSS complete onsite inspections and through observation, interview and record review ensure programs are following the regulations and providing services in accordance with the regulations. State regulation requires providers and their employees to adhere to a code of ethics which includes prohibition of committing any act of abuse, neglect or exploitation. In addition, all HCBS providers are required to report any known or suspected abuse, neglect or exploitation of a participant to the state.
DHSS utilizes ASPEN- the federal database required by CMS for Skilled Nursing Facility survey tracking- to also track their state licensed processes. Each inspection and any corresponding citations are entered into ASPEN. From this database, reports are run to determine the frequency of citations so that reports can be provided to the ADC providers on frequently cited citations and trends, and training programs can be tailored to address a particular area of concern. Reports can be run specifically on the incidence of restraints, and violations of participant rights being cited.
Additionally, DHSS utilizes ACTS, the federal database required by CMS for Skilled Nursing Facility complaint report tracking, to collect complaint allegations and to compile findings from investigations. DHSS is able to monitor complaints and corresponding statements of deficiency through ACTS and ASPEN in order to monitor current trends in citations- so that provider groups and DHSS can target industry training to ensure better understanding of regulations and compliance.
State regulations requires all Adult Day Care programs to ensure that each participant of the adult day care program be assured of the following rights: To be free of restraint, unless under physicians order as indicated in the individual's care plan.
The State Medicaid Agency has access to ASPEN, the federal database that houses all inspection/survey activity in the state for all levels of long term care and adult day care programs. They are able to review Statements of Deficiency (SOD)'s produced by SLCR at any time. MHD is also copied on all letters/licenses for new/existing/closed providers, and also are copied on all letters in regards to license denial or revocation.
Observation, interview and record review during inspections and complaint investigations to determine use and appropriateness of the use. Determine if the restraint was used only after a complete assessment and care planning. Ensure that only the least restrictive restraint has been used and appropriate for the individual participant to attain or maintain his or her highest practicable physical and psychosocial well-being. Monitor to ensure the program continues to assess and care plan the restraint use on an ongoing basis.
Section for Long Term Care Regulation (SLCR) prepares citation reports from ASPEN on an at least yearly basis to identify what citations are most frequently cited and uses the reports to provide training to adult day care providers on frequent citations.
Full licensure inspections are completed at least upon initial licensing, every two years prior to the expiration of the program license and then as needed for onsite revisits, complaint investigations, participant capacity changes, etc.
DHSS, the state licensing agency for Adult Day Care program, utilizes ASPEN- the federal database required by CMS for Skilled Nursing Facility survey tracking- to also track their state licensed processes. Each inspection and any corresponding citations are entered into ASPEN. From this database, reports are run to determine the frequency of citations so that reports can be provided to the ADC providers on frequently cited citations and trends, and training programs can be tailored to address a particular area of concern. Reports can be run specifically on the incidence of restraints being cited.
The operating agency conducts case record reviews of Aged and Disabled Waiver participants. These reviews include data regarding abuse, neglect, and exploitation. Additionally, the operating agency reports on use of restraints in Adult Day Care programs in cooperation with Division of Regulation and Licensure (DRL) the results of the case record reviews are reported to the State Medicaid Agency at least annually.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- (●) **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ( ) **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ( ) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participant records that document the participant has a back-up plan that is subject to the participant's needs and preferences. Numerator = Number of participant records that document the participant has a back-up plan that is subject to the participant's needs and preferences. Denominator = Number

of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

☐ **Continuously and Ongoing**
☐ **Other** Specify:

Performance Measure:
Number and percent of participant records that document the participant and/or family or legal guardian was provided information on who to contact regarding complaints. Numerator: Number of participant records that document the participant and/or family or legal guardian was provided information on who to contact regarding complaints. Denominator = Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each*	**Frequency of data aggregation and analysis***(check each that applies):*

that applies):	
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participant records where the participant/guardian received information/education on how and to whom to report abuse, neglect, and exploitation (ANE) and other critical incidents. Numerator = Number of records where the participant/guardian received information/education on how and to whom to report ANE and other critical incidents. Denominator = Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants with a hotline report resulting in an investigation initiated within required timeframes. Numerator = Number of waiver participants with a hotline report resulting in an investigation initiated within required timeframes. Denominator = Number of hotline investigations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Hotline database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Hotline Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
Number and percent of investigations regarding unexplained deaths of waiver participants reviewed and closed within required timeframes. Numerator = Number of investigations regarding unexplained deaths of waiver participants reviewed within required timeframes. Denominator = Total number of unexplained death hotline investigations reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Hotline Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of unauthorized use of restrictive interventions that were appropriately reported. Numerator = Number of unauthorized use of restrictive interventions that were appropriately reported. Denominator = Number of unauthorized use of restrictive interventions reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Hotline Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative**

		Sample Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on

the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants whose Person Centered Care Plan (PCCP) addresses their health needs. Numerator = Number of participants whose PCCP addresses their health needs. Denominator = Number of PCCP reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of ADW providers who have a registered nurse (RN) on staff assuring the clinical integrity of the HCBS program according to state regulation. Numerator: Number of providers who have a RN on staff assuring the clinical integrity of the HCBS program according to state regulation. Denominator: Number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMAC Provider Contract Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When an error is discovered during a Division of Senior and Disability Services (DSDS) case record review or one is identified in a DSDS report, a DSDS supervisor reviews the error, and works with the appropriate worker to address and remediate the error. General methods of remediation may include: service plan revisions, re- training staff, discussions during area and regional meetings and/or change in Division policy or procedure. Problems related to timely investigation of hotlines are addressed through staffing and or staff training and or policy and or procedures as deemed appropriate.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

- [ ] **Continuously and Ongoing**
- [ ] **Other**
  Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**
  Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated,

analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

No less than annually MHD Program Operation staff and DHSS Program Oversight staff meet to discuss the Quality Improvement Strategy described throughout the AIDS Waiver (0197), Adult Day Care Waiver (1021), Aged and Disabled Waiver (0026), Independent Living Waiver (0346) and Medically Fragile Adult Waiver (40190).

At this time, DHSS Program Oversight staff and MHD Program Operations staff jointly review the performance measures and analyze corresponding reports generated by both agencies. MHD and DSDS review the outcome of the reports to ensure they are meeting the assurances specified throughout the application and what, if any, action may be necessary for remediation and or system improvement.
Systemic errors and trends are identified by MHD and DSDS based on the reports for each performance measure using the number and percent of compliance.
Recommendations for system change may come from either agency however MHD will approve any changes to the Quality Improvement Strategy specified in the waiver application. Any changes in the Quality Improvement Strategy in the waiver application are implemented and monitored, as appropriate. Any changes will be included on the next 372 report.
System improvement activities related to participant health, welfare, and safety are the first priority for MHD and DSDS staff. Additional priorities are established based on the number and percent of compliance specified in the waiver reports for the Quality Improvement Strategy in the waiver.
Although individual problems are remediated upon discovery, performance measures that are significantly lower than 100% may need to be addressed as a systemic issue. Implementation of system improvement will be a joint effort between DSDS and MHD. System change related to delegated activities will be the responsibility of DSDS and those activities that are not delegated will be the responsibility of MHD. Follow-up discussions related to system improvement activities may be discussed at quarterly meetings but will be discussed no less than annually.
Systemic issues may require follow-up reports, policy and or procedure changes, as well as staff and/or provider training
MHD and DSDS will analyze the effectiveness of system improvement activities through the Quality Improvement Strategy reports and or additional reports that may be recommended by DSDS and or MHD when significant areas of concern are identified.
The QIS Spans all Missouri HCBS DHSS waivers, but data is stratified for each respective waiver.

ii. System Improvement Activities

	Frequency of Monitoring and Analysis*(check each*

Responsible Party*(check each that applies):*	*that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

A quality improvement report is developed annually based on performance measure reports and at a minimum will identify the systemic issue, the proposed resolution, and the established time frame for implementation. Established timeframes from the annual report for remediation activities will be discussed and reviewed during quarterly meetings. The report will be updated as appropriate when systemic remediation activities have been completed. Effectiveness of system improvement activities will be monitored no less than annually at the QIS meeting based on new reports on the established performance measures. Significant systemic issues will be addressed by MHD and/or DSDS through increased reporting or monitoring as deemed necessary and appropriate.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Home and Community Based Services Waiver Quality Management Strategy specified in the Adult Day Care Waiver (1021), Aged and Disabled Waiver (0026), and Independent Living Waiver (0346) are evaluated and updated no less than annually by MHD and DSDS. The process includes the review of performance measures, reports for performance measures and remediation activities resulting from discovery. Annually MHD and DSDS will determine if the QIS is providing the information and improvements necessary to meet the quality assurance performance measures as it relates to discovery, remediation, and improvement activities. The committee will evaluate the QIS process annually to determine if the process is working. If it is determined additional input is necessary, DSDS and MHD will request input from individuals involved in the authorization and/or delivery of ADCW, ADW, and ILW services. This could include providers, other stakeholders and/or DSDS and MHD staff from other units within the Divisions.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Providers are required to maintain financial records and service documentation on each waiver participant, including the name of the participant, the participant's MO HealthNet identification number, the date that the service was rendered, and the units of service provided. Providers are not required to have independent audits performed. Services provided through the Aged and Disabled Waiver must be prior authorized by state staff; prior authorizations are based on the agreed upon services established during the service planning process.

The provider subsequently receives payment directly from MO HealthNet as reimbursement. MO HealthNet makes a Remittance Advice indicating the disposition of billed claims available to the provider.

The Missouri Medicaid Audit & Compliance (MMAC) Unit within the Department of Social Services (DSS) conducts periodic compliance audits in which the documentation of services provided is reviewed to ensure that services billed to MO HealthNet were provided and documented as required per state regulation. The selection of participants is determined by what providers are selected to be audited during the audit period timeframe. It is MMAC's intent to review providers on a rotating basis, every three years. Providers are divided into thirds and approximately 1/3 of the providers are reviewed each year. A provider with a history of problematic billing or complaints may be "spot checked" regarding those focused areas, in addition to receiving regular periodic audits. Reviews are performed on-site. A desk audit may be considered for providers with few participants in an outer area of the state when it is not economically feasible to travel long distances to the provider's location to obtain a small number of records. A desk audit entails requesting records by mail or fax. Providers are generally given 15 business days to produce records for a desk audit. The provider may then mail, fax or email the requested records. Other than the requested records being sent in by the provider, the process is the same. The same in-depth review of records is completed and the same types and numbers of records are collected. Providers will receive a call and a fax 24 hours prior to the audit. The fax contains a notice to audit and a partial list of participant names that will be included in the audit. Once the audit has been finalized the provider will receive a letter outlining the violations and sanctions. The provider then has 30 days to appeal and 45 days to submit a plan of correction. Audits are conducted every three years. However, reviews may be conducted sooner if a complaint is received or if a follow-up audit on a provider that had major violations is completed.

Corrective action plans submitted by providers are reviewed and accepted or denied. Providers found to have egregious errors, both in type and/or volume, are monitored periodically and, if it appears from claims data the problem has not been resolved, another audit may occur, or an investigation may be opened, or both.

Each year, MMAC prepares a work plan for areas of focus. Input includes the OIG work-plan, CMS guidance and publications, trends, complaints and referrals, continued areas of non-compliance, and other factors. MMAC has a clinical services, HCBS, behavioral health, and mental health services review groups.

Reviews of HCBS providers are done at least once every three years. Reviews of all other providers are chosen based upon one or more factors, such as: work-plan, complaints/referrals/hotlines from the public, participants, other providers, other agencies such as licensing boards, Health and Senior Services, Mental Health, Medi-Medi contractor, or the Attorney General's office, length of time since last audit, amount billed to the state, aberrant or quickly trending upward billing, analytic results showing suspicious or aberrant billing patterns and follow up to prior audits.

Statistically valid samples are generally not used to determine which providers will be reviewed. The total number of HCBS providers is determined every year and divided into thirds and approximately 1/3 of the providers are reviewed each year. Should a current HCBS provider also be an Aged and Disabled Waiver provider, the review of the ADW provider would occur at that time; therefore, 100% of ADW providers will be reviewed at least every 3 years. Utilization reports and trends are monitored between audits, and complaints or referrals can trigger an audit.

Review results statistics are available upon request.

Providers have the responsibility of ensuring they have adequate documentation to support services prior to the filing of claims to MO HealthNet for reimbursement.

The State requires providers to retain documentation for five years, but generally utilizes a three year look back period due to availability of billing records. Audits generally encompass a period of one year or less.

The audit trail consists of documents located in the individual participant case records, the database utilized by DSDS for authorization of services, MO HealthNet, and the providers. The case records contain the service plan (basis for the prior authorization). Corresponding information is maintained in the DSDS database in order to electronically submit the prior authorization information to MMIS.

DSDS' waiver program expenditures are subject to the State of Missouri's Single State Medicaid Audit conducted by the Missouri State Auditor's office.

Documentation that support provider billing are reviewed such as service authorizations and provider monitoring logs. Verification of correct names, and the in and out times, etc. are also reviewed. Background screening is reviewed as part

of MMAC's audits/reviews. Some provider types are required to do criminal background checks and some are required to utilize the Family Care Safety Registry (FCSR) to do their checks, and some employees are required to be registered. This varies depending upon the HCBS provider type, and other provider types, as well. MMAC ensures employees are properly registered or have properly disclosed, and that initial and periodic screenings are performed, and that Good Cause Waivers are applied for and received as necessary. Verification of screening is requested and reviewed to see if the employees have been screened and that the screening was done timely. The participant's current plan of care and progress notes are reviewed to verify that the plan is being followed and that notes are being maintained. MMAC also audits/reviews for licensure qualifications, age qualifications, training and orientation qualifications, and other program specific qualifications, such as family members being personal care attendants or not. The scope of this process is not different as mentioned in other areas. Documents are either sent in to MMAC by the provider (desk review) or scanned while on-site at the provider's location (on-site review). MMAC personnel may access participant care plans through DCPH database. MMAC personnel are also independently able to verify employees' registration and screening through the FCSR. However, MMAC expects the providers to have access through the Web Tool or paper copies of participants' care plans and expects the providers to have documentation of employee registration and screening (and application and granting of a Good Cause Waiver, if necessary.) MMAC also expects to see any and all other documentation to support the provider's billing, such as time sheets, physician's orders, nurse visit reports, etc.

MMAC includes the violation in its list of violations (if any) sent to a provider in its final determination letter (audit findings).

MMAC then reviews its State Regulation pertaining to sanctions (13 CSR 70-3.030) to determine the appropriate sanction. Providers may have the improperly paid money recouped or they may face more serious sanctions such as suspension or termination. Providers may face less serious sanctions in situations where the money was properly paid (there was no adverse finding rendering the employee unqualified but the provider failed to timely screen the employee, for instance.)

During an audit, MMAC checks every single employee who has contact with every/any participant who is part of the audit. There is no sampling on this issue. MMAC will sample training and orientation documents during an audit, choosing the number dependent upon the number of employees.

Whether MMAC conducts a "desk review" or an on-site audit, the auditors collect or receive documents from the providers and those are compared to the claims the providers submitted (their billing) and the participant care plans. MMAC will determine if the services or products were authorized, if they were properly documented, if the billing is appropriate, and MMAC will also contact participants to determine if they received the services or products, when any question exists regarding actual provision of services.

All procedures described are part of the DSS periodic audit conducted by MMAC and not a separate post-payment procedure.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability Assurance:**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**
      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of paid waiver claims that had a prior authorization for services. Numerator = Number of paid waiver claims that had a prior authorization for services. Denominator = Total number of paid waiver claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each*	**Frequency of data aggregation and analysis***(check each that applies):*

that applies):	
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of paid waiver claims that are for services included in the approved waiver. Numerator = Number of paid waiver claims that are for services included in the approved waiver.Denominator= Total number of claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of providers with supporting documentation of services rendered for claims billed by the provider. Numerator: Number of providers with supporting documentation of services rendered for claims billed by the provider. Denominator = Total number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program Integrity Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Review of 25 Aged and Disabled providers annually.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of waiver rates paid that adhere to the rate methodology specified in the waiver. Numerator = Number of posted rates that adhere to the rate methodology specified in Appendix I-2-a. Denominator = Total number of waiver approved rates.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
State financial oversight exists to ensure claims are coded and paid in accordance with the reimbursement methodology in the approved waiver. Claims payment issues are the responsibility of MHD. MHD works to resolve payment issues as they are identified by MHD or DHSS. When an overpayment or underpayment has occurred, MHD recycles claims to pay or recoup appropriate funds. MMAC is responsible for provider reviews and identifying incorrect billings due to inadequate documentation, coding or unit errors or other findings. Remediation occurs through changes in policy, procedure or MMIS system edits or through the finalization of audits.

When payment issues are identified, MHD staff generate a System Problem Assistance Request to the state fiscal agent requesting information as to why a claim is not paying correctly. The state fiscal agent reviews the claims data to determine why a claim is not processing correctly. Once the problem is identified, the fiscal agent makes corrections to fix the problem. MHD staff review test documentation to ensure that the actions taken by the fiscal agent remedy the situation. Once the problem has been corrected, MHD staff monitor to ensure future claims pay correctly.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The reimbursement rates for services provided through the Aged and Disabled Waiver are subject to and determined by the State Legislature, through the State of MO annual budgeting/appropriation process. The state legislature works independently with legislative budgetary and research staff and the input of the Missouri provider industry and participants to develop rate changes during the annual appropriations process and development of the State budget.

The public is 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.

Participants and business entities have the opportunity to request rate increases as part of the annual legislative budget process. Any rate increase is subject to funding in the budget and may be increased if authorized by the State Legislature.

The Missouri State Legislature employs research staff who work in coordination with provider industry representatives and State agencies to determine inputs for development of rates.

The Missouri House of Representatives (MO HoR) has a standing Appropriations Committee for Health, Mental Health and Social Services. This committee develops initial recommendations for rates and this information is sent to the standing Select Committee on Budget for final decisions regarding rates being sent for a vote decision before the MO HoR.

In the Missouri Senate, there is a standing Appropriations Committee which reviews information gathered by its members to determine rates, which then go before the Senate for vote.

Rates for waiver services are historically based on four factors. These four factors are the Missouri hourly minimum wage, gas prices for the Midwest per gallon, the hourly amount for Aged and Disabled Waiver services and the Consumer Price Index. The state legislature has the opportunity to ask questions from state agencies during the appropriations process.

The State Legislature reviews rates annually during each legislative session (January - May). The legislature makes the decision regarding any updates at this time. Both MHD and DSDS provide historical utilization data to the Governors' budget office and appropriation committee that is used to apply a per unit increase to waiver services.

The rates established by the MO Legislature are statewide rates and do not vary by provider. Current reimbursement rates can be found on MO HealthNet's website at http://dss.mo.gov/mhd/providers/pages/cptagree.htm. Information regarding payment rates is available upon request by the participant, through the MHD Participant Services Unit or

online at the MHD website. Requests may be made in writing to the MHD or DHSS, by e-mail to ASK MHD, or by phone call to the MHD Participant Services Unit.

There is no set standard for analysis by legislative budgetary and research staff, providers, or participants for rate changes. The current maximum allowable rates for each service in the Aged and Disabled Waiver are based on historical waiver rates, are part of the core budget and have been adjusted over the years as funding is appropriated by the State Legislature. The historical data used to establish these rates have not been maintained and is not available.

Current rates are reasonable and remain sufficient to ensure continued access to quality of care as there is provider competition for services and allows for individual freedom of choice, and there is a lack of participant complaints regarding inability to select/find a provider, and lack of participant complaints regarding quality of care.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All services provided under this Waiver Program are prior authorized by Missouri Department of Health and Senior Services' (DHSS) staff. The prior authorization is forwarded to the MO HealthNet Fiscal Agent. Providers of services bill claims for services directly to the MO HealthNet Fiscal Agent for claims processing. All claims are processed through a MMIS. Claims are checked against services prior authorized. Only authorized services are paid. Payment is made directly to the provider of service.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

DHSS staff determines participant eligibility for waiver services and develop/finalize the service plan. Based upon the participant's approved service plan, services are then prior authorized. This information is then transferred to the MMIS for establishment of prior authorization for approved services against which all claims for payment from providers are compared.

The MMIS system incorporates an edit function that ensures services are only reimbursed to the provider for dates of service on which the participant is Medicaid eligible and only to providers who are enrolled on the date a service is delivered. No reimbursement will be made for units billed by the provider in excess of the authorized amount. Each time a claim is processed and paid, the number of units reimbursed to the provider is deducted from the number of units authorized.

The MMAC unit within the Department of Social Services conducts compliance audits in which the documentation of services provided is reviewed to ensure that services billed to MHD were provided and documented as required per Regulation. MMAC may arrange to conduct some interviews with waiver participants during monitoring; discussion of whether services were actually delivered is held during these interviews. When investigating a complaint, MMAC staff will also be verifying that services are delivered as reported. Providers are required to have adequate documentation of service delivery prior to filing claims for reimbursement through MMIS.

Providers have the responsibility of reviewing time sheets and meal delivery records and certifying their accuracy prior to the filing of claims to the MO HealthNet Division for reimbursement. Providers' procedures may include follow-up conversation with participants on actual service delivery.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS.

Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health**

plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ○ **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The □1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- ☐ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The Department of Health and Senior Services (DHSS) is appropriated the state funds for the Aged and Disabled Waiver. DHSS has filed an authorization letter with the Missouri Office of Administration indicating that MO HealthNet Division is approved to code the state portion of MO HealthNet expenditures for the Aged and Disabled Waiver against DHSS appropriations from the state's General Revenue fund.

Claims are processed through the MMIS and adjudicated for payment. During the adjudication process, the Department of Social Services/Division of Finance and Administrative Services has been granted authority by DHSS, to issue warrants to draw down funds from the DHSS state appropriation. Providers are then paid directly by the MO HealthNet Division.

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings: **Do not complete this item.**

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment

fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	2400.21	17202.00	19602.21	32425.00	12215.00	44640.00	25037.79
2	2571.77	17615.00	20186.77	33204.00	12508.00	45712.00	25525.23
3	3216.70	18038.00	21254.70	34001.00	12808.00	46809.00	25554.30
4	3101.53	18471.00	21572.53	34817.00	13116.00	47933.00	26360.47
5	3474.11	18914.00	22388.11	35652.00	13430.00	49082.00	26693.89

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	26932	26932
Year 2	26932	26932
Year 3	26932	26932
Year 4	26932	26932
Year 5	26932	26932

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay was determined using data from the 2013 - 2016 372 reports. The average length of stay is 341 days. The state used this data to find the average percentage change from year to year and projected that percentage growth forward from 2016 372 data to obtain the projected average length of stay for each waiver year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Average Units Per User: Average Units per user were determined projecting forward based on historical utilization data from 2013-2016 372 reports.
• Percentage change per year is calculated for 2013-2014, 2014-2015 and 2015-2016 372 data. The state then obtained the average percentage change from those three percentages and projected forward from the 2016 372 data using the average percentage increase for each waiver year.
Number of Users: The number of users by service type are projected forward based on historical number of users from 2013-2016 372 reports.
• Percentage change per year is calculated for 2013-2014, 2014-2015 and 2015-2016 372 data. The state then obtained the average percentage change from those three percentages and projected forward from the 2016 372 data using the average percentage increase for each waiver year. The state did not utilize 2013-2014 percentage growth data as the service was originally introduced in the waiver during this period and the large growth during that period would have skewed the data. Projected number of users for Block Basic Respite were added into Basic Respite projections to account for the transition of the service. Projected number of users for Block and Daily Advanced Respite were added into the Advanced Respite projections to account for the transition of the service.

Average Cost Per Unit: The rates for each year are projected forward based on historical data of actual rates from the past three years, which corresponded with the year of the 2013-2016 372 reports.
• Percentage change per year is calculated for 2013-2014, 2014-2015 and 2015-2016 372 data. The state then obtained the average percentage change from those three percentages and projected forward from the 2016 372 data using the average percentage increase for each waiver year.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D’ was trended forward annually using actual expenditures from waiver year 2016 at the FY17 2.4% market basket rate. The waiver year 2016 D’ value is $16,020.61

The State's reporting system is able to identify a participant's Medicare eligibility and whether or not the participant has Part D coverage. The expenditures for pharmaceutical claims included in the D' estimates were arrived at by excluding any claims that were processed/paid when the participant was eligible for Medicare Part D. Medicare Part D is not a factor in our determination of Factor D'.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was trended forward annually at the FY 17 market basket rate of 2.4% using actual 2016 expenditures. The waiver year 2016 Factor G value was $30,198.59.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G’ was trended forward annually at the FY 17 market basket rate of 2.4% using actual 2016 expenditures. The waiver year 2016 Factor G‘ value was $11,375.93. Medicare Part D is not a factor in our determination of Factor G'.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Adult Day Care
Basic Respite
Homemaker
Advanced Respite
Chore
Home Delivered Meal

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**6257463.84**
Adult Day Care	15-minute unit	908	2836.00	2.43	**6257463.84**	
Basic Respite Total:						**34937978.12**
Basic Respite	15-minute unit	4891	1669.00	4.28	**34937978.12**	
Homemaker Total:						**4904237.52**
Homemaker	15-minute unit	1734	588.00	4.81	**4904237.52**	
Advanced Respite Total:						**3756599.84**
Advanced Respite	15-minute unit	421	1736.00	5.14	**3756599.84**	
Chore Total:						**5209.23**
Chore	15-minute unit	19	57.00	4.81	**5209.23**	
Home Delivered Meal Total:						**14781058.72**
Home Delivered Meal	Meal	10243	232.00	6.22	**14781058.72**	
				GRAND TOTAL:		**64642547.27**
				Total Estimated Unduplicated Participants:		**26932**
				Factor D (Divide total by number of participants):		**2400.21**

Average Length of Stay on the Waiver:	281

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**6563012.52**
Adult Day Care	15-minute unit	934	2822.00	2.49	**6563012.52**	
Basic Respite Total:						**36561168.00**
Basic Respite	15-minute unit	4980	1680.00	4.37	**36561168.00**	
Homemaker Total:						**3338412.11**
Homemaker	15-minute unit	1243	547.00	4.91	**3338412.11**	
Advanced Respite Total:						**5782507.50**
Advanced Respite	15-minute unit	589	1870.00	5.25	**5782507.50**	
Chore Total:						**5008.20**
Chore	15-minute unit	20	51.00	4.91	**5008.20**	
Home Delivered Meal Total:						**17012856.50**
Home Delivered Meal	Meal	11210	239.00	6.35	**17012856.50**	
				GRAND TOTAL:		**69262964.83**
				Total Estimated Unduplicated Participants:		**26932**
				Factor D (Divide total by number of participants):		**2571.77**
				Average Length of Stay on the Waiver:		271

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**6861291.84**
Adult Day Care	15-minute unit	962	2808.00	2.54	**6861291.84**	
Basic Respite Total:						**38307846.36**
Basic Respite	15-minute unit	5068	1691.00	4.47	**38307846.36**	
Homemaker Total:						**2279149.20**
Homemaker	15-minute unit	892	510.00	5.01	**2279149.20**	
Advanced Respite Total:						**19589545.80**
Advanced Respite	Meal	12270	246.00	6.49	**19589545.80**	
Chore Total:						**4734.45**
Chore	15-minute unit	21	45.00	5.01	**4734.45**	
Home Delivered Meal Total:						