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 waivers 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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. Program Title:
AIDS Waiver

C. Waiver Number:MO.0197
Original Base Waiver Number: MO.0197.90.R2.01

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/23
Approved Effective Date of Waiver being Amended: 11/01/22

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Significant changes made with this amendment include modifying a performance measure, updating the rate methodology, and protocol changes for the State's response to critical events or incidents.

Funding for waiver services includes funding from the temporary 10 percentage point increase to the FMAP for Medicaid expenditures for home and community-based services provided under section 9817 of the American Rescue Plan Act of 2021 (ARP). Utilization of ARP funding will continue until all funds are exhausted, at which time funding of the State match will switch to all State general/tax revenue.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver	

Component of the Approved Waiver Application	Subsection(s)
☐ Appendix A Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☐ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☒ Appendix G Participant Safeguards	G-1 b, G-1d, G-1 e
☐ Appendix H	
☒ Appendix I Financial Accountability	I-2a, QI
☒ Appendix J Cost-Neutrality Demonstration	J-2 c, J-2 d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☒ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

Update rate methodology and one performance measure's sampling approach in Appendix I, and protocol changes for the State’s response to critical events or incidents in Appendix G.

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*):

AIDS Waiver

C. Type of Request: amendment

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.0197
Draft ID: MO.007.07.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 11/01/22
Approved Effective Date of Waiver being Amended: 11/01/22

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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**

☒ **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:

The State does not limit 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:

☒ **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.

The Missouri Medicaid AIDS Home and Community-Based Waiver is designed for persons living with HIV/AIDS that, due to their disease, have a decreased level of function. The waiver allows qualified HIV-positive, Medicaid-eligible clients to receive care in their homes as a cost-effective alternative to placement in a nursing facility. The main goal of the waiver is to encourage the client to reach an optimal level of function through services within the community. Objectives include: 1) Provide individual choice between institutional care and comprehensive community-based care in a cost effective manner, 2) Maintain and improve a community-based system of care that diverts participants from institutional care and residential care, 3) Ensure the adequacy of medical care and services provided, 4) Monitor each participant's condition and continued appropriateness of participation through ongoing reassessments, and 5) Monitor provider provision of service and the appropriateness of the services provided. The Missouri Department of Social Services, MO HealthNet Division, serves as the state's Medicaid agency, and administers the AIDS Waiver along with all other Medicaid benefits. The Department of Social Services (DSS) has an inter-agency agreement with the Department of Health and Senior Services (DHSS) to assess clients for waiver services.

The State of Missouri is the recipient of the Medicaid AIDS Home and Community-Based Waiver under section 1915(c) of the Social Security Act. This waiver permits state Medicaid agencies to cover services that exceed program limitations or that are not included in the standard Medicaid benefit package or state plan. The waiver allows eligible clients to receive the following services:

*Waiver Personal Care Services (WPC)- personal care units in excess of the number of units allowed through Medicaid's State Plan Personal Care (SPPC) benefits package.

*HIV/AIDS supplies- gloves, diapers, underpads.

*Attendant Care Services- Attendant Care (AC) offers supportive and health-related services. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Services are provided on a prior authorized basis which eliminates the duplication and overlap in services (i.e., Authorized Nurse Visit, Personal Care) by not providing the same service at the same time on the same day.

Service Delivery Methods: Waiver services are accessed primarily through medical case manager referral of individuals who meet the criteria of the waiver and desire to remain in their homes. Referrals are also accepted from health care providers, families, other state agencies and other sources. Contracted Waiver Case Managers complete assessments for waiver eligibility. The DHSS Quality Service Manager reviews Waiver Case Manager authorized services and units of service, and provides approval prior to the initiation of services. Other DHSS staff that may authorize services within the Bureau of HIV, STD, and Hepatitis include the Chief, Assistant Chief, and Director of HIV Medical Case Management.

Participants and/or responsible parties are provided with a list of service providers available in the area in which they live. Participants and/or responsible parties may choose their provider and may change providers at any time. Services are prior authorized and are subject to approval by the State Medicaid Agency, MO HealthNet Division. Providers are paid directly through the MO HealthNet Electronic Medicaid Management Information System.

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:

For this waiver amendment application, the Department of Social Services (DSS), MO HealthNet Division (MHD) and the Department of Health and Senior Services (DHSS), Bureau of HIV, STD and Hepatitis invited the public to comment.

The public comment notice, along with a complete copy of the renewal application, was published on the DSS website on XX, XX, 2023, located at the following link: https://dss.mo.gov/mhd/alerts~public-notices.htm. The public comment notice was also published in the five (5) newspapers within Missouri for cities with the greatest population on XX, XX, 2023. Complete copies of the amendment were also available by request from the DHSS Bureau of HIV, STD and Hepatitis (BHSH) on-line at: http://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php, by phone, mail or in-person. Contact information for the BHSH was provided in the public comment notice.

The public was informed via public notice that comments would be accepted by MHD directly via mail or email, and contact information for the MHD was provided in the public notice. The public notice included the mailing address, email and contact information used to receive comments from the public, and provided the following contact information: MO HealthNet Division, P.O. Box 6500, Jefferson City, MO 65102-6500, Attn: MO HealthNet Director, Email: AskMHD@dss.mo.gov. Per the notice, complete copies of the renewal application were also available on the MHD alerts and public notice webpage at https://dss.mo.gov/mhd/alerts~public-notices.htm, or by request from the Department of Health and Senior Services Bureau of HIV, STD and Hepatitis; on-line, by phone at (573) 751-6475 or by mail at PO Box 570, Jefferson City, MO 65102-0570.

Public input was taken allowing written comments from XX, XX, 2023, through end of business day XX, XX, 2023.

On XX, XX, 2023, the State notified in writing the federally-recognized Tribal Government known as the Urban Indian Organization of the State's intent to submit a waiver amendment application.

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: Kremer

First Name: Glenda

Title: Assistant Deputy Director

Agency: Missouri Department of Social Services, MO HealthNet Division

Address: PO Box 6500

Address 2: 615 Howerton Court

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: Hampton

First Name: Dustin

Title: Bureau Chief- Bureau of HIV, STD and Hepatitis

Agency: Missouri Department of Health and Senior Services

Address: PO Box 570

Address 2: 930 Wildwood Drive

City: Jefferson City

State: **Missouri**

Zip:

65102-0570

Phone:

(573) 526-2610 **Ext:** ☐ **TTY**

Fax:

(573) 751-6447

E-mail:

Dustin.Hampton@health.mo.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

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:

Richardson

First Name:

Todd

Title:

Division Director

Agency:

MO HealthNet

Address:

615 Howerton Ct

Address 2:

City:

Jefferson City

State: **Missouri**

Zip:

65109

Phone:

(573) 751-6922 **Ext:** ☐ **TTY**

Fax:

(573) 751-6564

E-mail:

leann.hager@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 this waiver amendment will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan. The State will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

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/ Bureau of HIV, STD and Hepatitis

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, Bureau of HIV, STD and Hepatitis is performing the delegated waiver operational and administrative functions in accordance with the waiver requirements during the period that 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. An MOU exists between the two agencies, and communication remains open and additional discussions occur on an ongoing and as needed basis.

MHD reviews reports submitted quarterly by DHSS 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 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.:*

The contracted entities consist of HIV Medical Case Management agencies (includes Non-profit Community Based Organizations, Local Public Health Agencies, Universities, Hospitals, etc.) who have been contracted by DHSS to provide HIV case management services, including AIDS Waiver, to participants.

These contracted entities perform the following functions:
1) Disseminate information concerning the waiver to potential enrollees.
2) Assist individuals in waiver enrollment.
3) Monitor waiver enrollment managed against approved limits.
4) Monitor waiver expenditures managed against approved levels.
5) Conduct level of care (LOC) evaluation activities.
6) Develop and reassess participant service plans.
7) Quality assurance and quality improvement activities.

○ **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:

Select local public health agencies (LPHAs) are contracted through DHSS to provide HIV Medical Case Management for persons living with HIV/AIDS, including performing waiver operational and administrative functions at the local level with oversight from DHSS. DHSS holds contracts with these agencies that set out the responsibilities and performance requirements. Participation in administrative/operational functions include: disseminate information concerning the waiver to potential enrollees; participant waiver enrollment; waiver enrollment managed against approved limits; waiver expenditures managed against approved levels; level of care assessment and reassessment; development of participants' service plans; quality assurance and quality improvement activities and other services as needed. DHSS Quality Service Managers review all participant service plans, including authorized service units and provide approval, development of rules, policies, procedure and information governing the waiver program. Other DHSS staff that may review and authorize participant service plans within the Bureau of HIV, STD, and Hepatitis include the Chief, Assistant Chief, and Director of HIV Medical Case Management.

☒ **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:

Select agencies (Non-profit agencies, Hospitals, Community Based Organizations, etc.) are contracted through DHSS to provide HIV Medical Case Management for persons living with HIV/AIDS, including performing waiver operational and administrative functions at the local level with oversight from DHSS. Participation in administrative/operational functions include: disseminate information concerning the waiver to potential enrollees; participant waiver enrollment; waiver enrollment managed against approved limits; waiver expenditures managed against approved levels; level of care assessment and reassessment; development of participants' service plans; quality assurance and quality improvement activities and other services as needed. DHSS Quality Service Managers review all participant service plans, including authorized service units and provide approval, development of rules, policies, procedure and information governing the waiver program. Other DHSS staff that may review and authorize participant service plans within the Bureau of HIV, STD, and Hepatitis include the Chief, Assistant Chief, and Director of HIV Medical Case Management.

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:

DHSS maintains responsibility for assessment of performance of contracted entities.

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:

DHSS conducts an annual site visit with each of the contracted entities to assess the performance of the operational and administrative functions in accordance with Waiver requirements.

DHSS performs quarterly record reviews using a standardized review instrument developed by the state Medicaid agency. The review instrument contains specific operational and administrative components that pertain to the CMS assurances.

Upon completion of quarterly record reviews, the results are provided to the MO HealthNet Division (MHD) for review and analysis to determine compliance with the waiver requirements. MHD provides a formal report of any deficiencies identified. A corrective action plan is requested from DHSS outlining how the deficiencies will be corrected and a timeline for correction. MHD monitors the corrective action plan to ensure the timeline for correction is met and discusses actions during the quarterly quality meetings.

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	Contracted Entity	Local Non-State Entity
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 States quality improvement strategy, provide information in the following fields to detail the States 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 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 manuals and directives reviewed by MHD that are applicable to the waiver. Numerator = Number of manuals and directives applicable to the waiver reviewed by MHD. Denominator = Total number of manuals and directives applicable to the waiver 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of waiver participants for whom service units paid did not exceed authorized units of service. Numerator = Total number of waiver participants for whom paid waiver service units did not exceed authorized units of service. Denominator = Total number of waiver participants.

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 quarterly meetings held during a waiver year to discuss performance measure findings from DHSS, BHSH's quarterly reviews. Numerator=Number of quarterly meetings held during the waiver year that focused on findings from BHSH's quarterly reviews. Denominator=total number of quarterly meetings that were required to be held.

Data Source (Select one):
Meeting minutes
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:

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 States 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 MHD's attention through review of DHSS reports, as well as through day-to-day activities of the MHD, e.g., review/approval of provider agreements, utilization review and quality review processes, complaints from MHD 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 DHSS and advising them of the issue. A follow-up memo or email is sent from MHD to DHSS identifying the problem and, if appropriate, a corrective action resolution. While some issues may need to be addressed immediately, DHSS is required to provide a written response to MHD that specifically addresses the problem identified by MHD. Written documentation is maintained by both MHD and DHSS 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			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☒ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☒	HIV/AIDS	21		☒
	☐	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:

In order to receive AIDS Waiver Services, a client must be HIV positive, age 21 or greater, and enrolled in HIV Medical Case Management.

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:

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	161
Year 2	161
Year 3	

Waiver Year	Unduplicated Number of Participants
	161
Year 4	168
Year 5	186

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:

Individuals would be selected on a first come first serve basis in the event of a waiting list.

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**
- [x] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **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)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **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)**

☒ **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:

The following are additional eligibility groups that may receive services under this waiver:

ME38 42 CFR 435.145
ME05 42 CFR 435.110; Section 1902(a)(10)(A)(i)(I) of the Social Security Act (SSA); Section 1931(b) and (d) of the SSA
ME18, ME45, ME61, ME43, ME44 42 CFR 435.116; Section 1902(a)(10)(A)(i)(III) and (IV) of the SSA; Section 1902(a)(10)(A)(ii)(I), (IV) and (IX) of the SSA; Section 1931(b) and (d) of the SSA; Section 1920 of the SSA
ME95, ME96 RSMo 208.662; 13 CSR 40-7.060; 42 CFR 457.10; Section 2112 of the SSA; Section 1931(b) and (d) of the SSA

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:

☐ **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:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down 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:

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:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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 submit Appendix B-5 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.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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-4 indicate that you do not need to submit Appendix B-5 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 submit Appendix B-5 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.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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 a government agency under contract with the Medicaid agency.**

Specify the entity:

- ◉ **Other**

Specify:

Contracted entities (Waiver case managers) perform level of care evaluations and reevaluations for AIDS Waiver participants. These contracted entities consist of local public health agencies, not-for-profit community agencies, university hospitals, etc. These entities are contracted by the operating agency, DHSS, under the Ryan White HIV case management program.

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:

Waiver case managers must be a Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), or Registered Nurse (R.N.). Waiver training is completed prior to beginning case management of AIDS Waiver clients and yearly to assure quality of care.

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.

For October 31, 2021 through state spending of section 9817 ARP funding, a dual LOC criteria approach will be used. This approach will use the current LOC criteria as well as the transformed LOC criteria. Upon expenditure, the current criteria will be retired and only the transformed will remain in effect.

The HIV Specialty Level of Care (HIVLOC) instrument is used for initial evaluation and reevaluation of Level of Care. In order to be eligible for entry to the AIDS Waiver, individuals must meet nursing facility level of care as specified in state regulation at 19 CSR 30-81.030. Assessment must include a minimum of two (2) medical criteria.

Note: The transformed LOC point designations in this renewal application differ from the previously-approved point designations, as the State aligned the transformed LOC point designation with state regulation, 19 CSR 30-81.030, when it was discovered that several transformed LOC point designations were inadvertently left off during a previous waiver amendment process. The State updated the waiver application to align with state regulation 19 CSR 30-81.030. No negative impact to waiver applicants or participants undergoing reassessment is expected based on this change, as the assessment tool itself reflects the correct point designations. The State will continue to use the agreed-upon dual review for the duration of the MOE period for evaluations and reevaluations.

Current LOC Criteria:

Mobility: 0, 3, 6, or 9 points are assigned based on ability of the individual to move from one location to another.

Dietary: 0, 3, 6, or 9 points are assigned based on the individual's ability to eat and the capacity to prepare meals.

Restorative Services: 0, 3, 6 or 9 points are assigned for teaching programs designed to train the individual or a caregiver to do specific activities.

Monitoring: 0, 3, 6 or 9 points are assigned for monitoring of a specific physical condition by a physician or LPN/RN.

Medication: 0, 3, 6 or 9 points are assigned for physician ordered and regularly used over-the-counter medications which the individual should be taking.

Behavioral: 0, 3, 6 or 9 points are assigned according to the individual's condition regarding orientation, memory, and judgment.

Treatment: 0, 3, 6 or 9 points are assigned for any systemic course of nursing procedure for specific conditions and are ordered by a physician.

Personal Care: 0, 3, 6 or 9 points are assigned for activities of daily living, including hygiene; personal grooming, and bowel and bladder functions.

Rehabilitation: 0, 3, 6 or 9 points are assigned for therapeutic services provided by, or under the supervision of, a qualified therapist to restore a former or normal level of functioning.

Medical Criteria:

1. Multi-organ failure (ex. liver, kidney, heart, pancreas, lung)

2. Support to maintain vital function and/or maintain complex IV therapy, peripheral nutrition, central venous catheters, daily diabetic blood sugar tests and insulin injection.

3. Assessment and assistance with pain control and/or pain therapy during acute and terminal phase of illness.

4. Oversight as related to dementia, and/or severe chronic and persistent mental illness (ex. bipolar, multiple suicide attempts, schizophrenia, and confusion)

5. Oversight related to terminal phase of illness.

6. Licensed nursing care on a regular basis to assist in recovering from opportunistic infections and/or acute illnesses.

7. Weekly monitoring required by a licensed nurse and/or physician in order to provide assessment for opportunistic infection (CD4, VL, signs, and symptoms).

8. Licensed nursing care on a regular basis to assist with medication set up, adherence and monitoring for serious side effects.

9. Monitoring and assistance to maintain safety/optimum mobility related to neurological deficits (ex. neuropathy or uncontrolled seizures).

10. Oversight as a result of comorbid complications (ex. Substance abuse, secondary disease processes, TB, and hepatitis).

Transformed LOC Criteria:

Behavioral: 0, 3, 6 or 9 points are assigned if the individual receives monitoring for a mental condition, exhibits mood or behavioral symptoms or if the individual exhibits a psychiatric condition.

Cognition: 0, 3, 6, 9 or 18 points are assigned if the individual has issues with cognitive skills, memory or recall ability, disorganized thinking/awareness, and the ability to understand others or be understood.

Mobility: 0, 3, 6 or 18 points are assigned based on ability of the individual to move from one location to another and the amount of assistance needed.

Eating: 0, 3, 6, 9 or 18 points are assigned based on the individual’s ability to eat, the capacity to prepare meals, or if the individual requires a physician ordered therapeutic diet.

Toileting: 0, 3, 6 or 9 points are assigned based on the amount of assistance the individual needs with toileting or transferring on and off the toilet.

Bathing: 0, 3 or 6 points are assigned based on the amount of assistance the individual needs with bathing.

Dressing and Grooming: 0, 3 or 6 points are assigned based on the amount of assistance the individual needs with personal hygiene or dressing the upper and lower body.

Rehabilitation: 0, 3, 6 or 9 points are assigned for therapeutic services provided by, or under the supervision of a qualified therapist to restore a former or normal level of functioning.

Treatment: 0 or 6 points are assigned if the individual needs one or more of the following treatments: catheter/ostomy care, alternate modes of nutrition, suctioning, ventilator/respirator, or wound care for broken skin.

Meal Prep: 0, 3 or 6 points are assigned based on the amount of assistance the individual needs to prepare meals.

Medication Management: 0, 3 or 6 points are assigned based on the individual’s ability to safely manage their medications.

Safety: 0, 3, 6, 9 or 18 points are assigned based on the individual’s assistance needed in one or more of the following areas: vision, falling, balance, institutionalization, or if age 75 or older.

Additionally, four automatic qualifiers are included in the eligibility criteria: (1) no discernable consciousness, unable to make any decisions (2) total dependence to eat (3) bed-bound (4) age 7 or older with a safety score of six. These four pieces of the criteria termed as "triggers" are a "common Sense" approach for individuals that should automatically meet LOC due to their full dependence on others. Upon meeting LOC, a person-centered approach is taken to determine the specific services available for authorization based on established service authorization guidelines.

To be eligible for the waiver for both the current and transformed LOC, an individual must be meet a minimum of two of

the following medical criteria:

1. Multi-organ failure (ex. liver, kidney, heart, pancreas, lung)

2. Support to maintain vital function and/or maintain complex IV therapy, peripheral nutrition, central venous catheters, daily diabetic blood sugar tests and insulin injection.

3. Assessment and assistance with pain control and/or pain therapy during acute and terminal phase of illness.

4. Oversight as related to dementia, and/or severe chronic and persistent mental illness (ex. bipolar, multiple suicide attempts, schizophrenia, and confusion)

5. Oversight related to terminal phase of illness.

6. Licensed nursing care on a regular basis to assist in recovering from opportunistic infections and/or acute illnesses.

7. Weekly monitoring required by a licensed nurse and/or physician in order to provide assessment for opportunistic infection (CD4, VL, signs, and symptoms).

8. Licensed nursing care on a regular basis to assist with medication set up, adherence and monitoring for serious side effects.

9. Monitoring and assistance to maintain safety/optimum mobility related to neurological deficits (ex. neuropathy or uncontrolled seizures).

10. Oversight as a result of comorbid complications (ex. Substance abuse, secondary disease processes, TB, and hepatitis).

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 HIVLOC is reflective of the twelve criteria specified in 19 CSR 30-81.030 to determine institutional level of care, but places additional emphasis on the needs of persons living with HIV/AIDS. The HIVLOC assesses all of the twelve criteria using the parameters and scoring as specified in 19 CSR 30-81.030.

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 the current and transformed LOC tools for nursing facility admission and waiver services use the same scoring methodology described for each tool in Appendix B-6-d. The categories and scoring methodologies are established in the state nursing facility regulation. Since the nursing facility and waiver tools each utilize the same categories and scoring methodology for the current LOC and also use the same categories and scoring methodology for the transformed LOC and are based on the same state regulations, the outcomes from the waiver LOC instruments are reliable, valid, and fully comparable to the nursing facility LOC instruments.

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:

All participants enrolled in HIV Medical Case Management are assessed a minimum of annually by general medical case managers utilizing the Missouri Case Management Assessment Tool (MCMAT)to determine the need for assessment for in-home services. The MCMAT assesses the client's current functioning and possible deficits in the following four areas: health, social, financial and self-determination.

If it is determined that the participant may require in-home services, a referral is made to a Waiver case manager for assessment of suitability for AIDS Waiver services utilizing the HIVLOC which is the selected instrument for evaluation of Level of Care for potential Waiver participants.

During the dual LOC criteria timeframe outlined in B-6-d, the transformed LOC criteria will be first utilized to determine participant eligibility. If participant eligibility is not met under the transformed LOC criteria, the current LOC criteria will be used. Upon sunset of the current LOC criteria, only the transformed LOC criteria will be used. Reevaluations will be conducted in the order previously stated.

AIDS Waiver reevaluations are conducted by the Waiver case manager annually or more frequently based on any change in the participant's condition that warrants an increase in services. The HIVLOC is used for both the initial evaluation for AIDS Waiver services, as well as for subsequent reevaluations.

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:

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):*

AIDS Waiver LOC reevaluations are conducted annually or more frequently based on any change in the participant's condition that warrants an increase in services. Waiver services are authorized for a maximum of one year; if reevaulation does not occur, services are not extended. The AIDS Waiver Program Coordinator monitors continuing services as well as discontinuation of services. Additionally, the AIDS Waiver audit process monitors timely completion of reevaluations. Waiver case managers utilize a variety of reminders/ticklers to ensure timely reevaluations. Ongoing services are not authorized without a reevaluation.

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:

AIDS Waiver records are stored in a secure electronic client database and are maintained for a minimum of seven (7) years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 level of care (LOC) determinations completed for all applicants/participants indicating a need for NH LOC. Numerator = Number of LOC determinations completed for all applicants/participants indicating a need for NH LOC. Denominator = Total number of applicants/participants indicating a need for NH LOC.

Data Source (Select one):
On-site observations, interviews, monitoring
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:

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.

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 applicants who had initial Level of Care (LOC) determinations completed by qualified staff. Numerator = Number of applicants who had initial LOC determinations completed by qualified staff. Denominator = Total number of initial level of care determinations reviewed.

Data Source (Select one):
Record reviews, off-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:
	☐ **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 applicants who had a LOC instrument applied appropriately for the initial assessment. Numerator = Number of applicants who had a LOC instrument applied appropriately for the initial assessment. Denominator = Total number of applicants with initial LOC instrument applied.

Data Source (Select one):
Record reviews, off-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:
	☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **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 States 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.

The Quality Service Manager (QSM) reviews all Waiver Level of Care Determinations to assure that eligibility is met for initial enrollment and subsequent reevaluations. The QSM consults with the HIV medical case manager regarding any needed corrective action. The HIV medical case manager is responsible for correcting the deficiency. If the deficiency is unable to be corrected, the HIV medical case manager will report back to the QSM. The QSM will then follow DHSS approved processes to determine what further action is required.

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:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

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).

The HIV medical case manager discusses options and alternatives to Waiver services with the individual, their legal representative, or any other persons the individual requests. The Client Choice Statement is discussed and signed by the participant and/or responsible party prior to receipt of Waiver services. The Client Choice Statement indicates choice between Waiver care vs. institutionalization, choice of provider agency, and choice of who participates in service plan development.

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.

The Client Choice Statement is scanned and maintained in the electronic client database. Records are kept a minimum of seven (7) years.

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 contractor and persons with limited English proficiency to facilitate participation in, and meaningful access to case management services.

Applicants for, or recipients of services from 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		
Extended State Plan Service	**Waiver Personal Care**		
Other Service	**Attendant Care**		
Other Service	**Private Duty Nursing**		
Other Service	**Specialized Medical Supplies**		

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:

Extended State Plan Service

Service Title:

Waiver Personal Care

HCBS Taxonomy:

Category 1: 08 Home-Based Services

Sub-Category 1: 08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Waiver Personal Care (WPC) services are provided when the limits of Personal Care under the approved State plan are reached. WPC allows the addition of non-medical care, supervision, and socialization provided to a functionally impaired adult. Tasks performed include but are not limited to: dressing and grooming, dietary, bathing and personal hygiene, bath/shower standby, mobility and transfer, toileting and continence, meal preparation/supervision, dishwashing, kitchen surface/appliance cleaning, bathroom fixture cleaning, changing/making beds, sweeping/vacuuming/scrubbing floors, tidying, dusting, laundry, trash removal, grocery shopping, escort for transportation, correspondence on participants' behalf, etc. The provider qualifications specified in the State plan apply. Services are provided on a prior authorized basis to eliminate the potential of duplication and overlap.

The state does not make retainer payments to personal assistance when the waiver participant is hospitalized or absent from his/her home.

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

Waiver Personal Care (WPC) services are provided when the limits of Personal Care under the approved State plan are reached. Services are provided on a prior authorized basis to eliminate the potential of duplication and overlap. The state does not make retainer payments to personal assistance when the waiver participant is hospitalized or absent from his/her home.

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	Personal Care Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Waiver Personal Care

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

There are no licensing requirements.

Certificate *(specify):*

There are no certification requirements.

Other Standard *(specify):*

Medicaid Enrolled Provider and have a contract with the Department of Social Services, Missouri Medicaid Audit Compliance to provide Personal Care Services. The provider qualifications are outlined in 19 CSR 15-7.021. The personal care attendant selected by the waiver participant must be screened and employable pursuant to the Family Care Safety Registry, Employee Disqualification List and applicable state laws and regulations by the Personal Care Agency.

Personal Care providers are contracted with the Missouri Medicaid Audit and Compliance (MMAC) Provider Enrollment unit and enrolled with MO HealthNet. Providers of Personal Care are reviewed by MMAC to ensure that aids meet the following requirements:
1. Be at least eighteen (18) years of age;
2. Be able to read, write and follow directions; and
3. Have at least six months paid work experience as an agency homemaker, nurse aide, maid or household worker, or at least one year of experience in caring for children or for sick or aged individuals. Successful completion of formal training in the nursing arts, such as nursing aide or home health aide, may be substituted for the qualifying experience.
4. If the personal care attendant is providing advanced personal care, the aide must meet the criteria above to provide basic personal care and must meet the following additional criteria:
5. Be an LPN or a certified nurse assistant;
6. Be a competency evaluated home health aide having completed both written demonstration portions of the test required by the Missouri Department of Health and Senior Services and 42 CFR 484.36; or
7. Have successfully worked for the personal care provider agency for a minimum of three consecutive months while working at least fifteen hours per week as an in-home aide that has received personal care training.

The personal care attendants must be screened and employable pursuant to the Family Care Safety Registry, Employee Disqualification List and applicable state laws and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Social Services, Missouri Medicaid Audit Compliance.

Frequency of Verification:

Personal Care Providers are generally audited every three years by MMAC, but it can vary depending on whether a complaint or allegation of fraud or other program violations are received.

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:

Attendant Care

HCBS Taxonomy:

Category 1: 02 Round-the-Clock Services

Sub-Category 1: 02031 in-home residential habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Attendant Care (AC) offers supportive and health-related personal care services; these services are provided in the participant's home (includes single-family homes, single-room occupancy units, and other homelike living arrangements). Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant care is paid at a per diem rate. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Services are provided on a prior authorized basis which eliminates the duplication and overlap in services (i.e., Authorized Nurse Visit, Personal Care) by not providing the same service at the same time on the same day. Services listed in the service plan that are within the scope of the State's Nurse Practice Act are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

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

None.

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	Personal Care Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care

Provider Category:
Agency

Provider Type:

Personal Care Provider

Provider Qualifications

License *(specify):*

Approved MO HealthNet Personal Care Provider. 13 CSR 70-3.020 and 13 CSR 70-91.010.

Certificate *(specify):*

Other Standard *(specify):*

Must have signed AIDS Waiver addendum. Personal Care provider contracted with Missouri Medicaid Audit & Compliance and enrolled with MO HealthNet.
Personal care attendants must meet the following qualifications:
1. Be at least eighteen (18) years of age;
2. Be able to read, write and follow directions; and
3. Have at least six months paid work experience as an agency homemaker, nurse aide or household worker, or at least one year of experience, paid or unpaid, in caring for children, sick or aged individuals or have successfully completed formal training, such as the basic nursing arts course of nurse's training, nursing assistant training or home health-aide training.
4. If the personal care attendant is providing advanced personal care, the aide must meet the criteria above to provide basic personal care and must meet the following additional criteria:
a) Be an LPN or a certified nurse assistant;
b) Be a competency evaluated home health aide having completed both written demonstration portions of the test required by the Missouri Department of Health and Senior Services and 42 CFR 484.36; or
c) Have successfully worked for the personal care provider agency for a minimum of three consecutive months while working at least fifteen hours per week as an in-home aide that has received personal care training.
The personal care attendants must be screened and employable pursuant to the Family Care Safety Registry, Employee Disqualification List and applicable state laws and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Senior Services; Department of Social Services, MO HealthNet Division, Missouri Medicaid Audit Compliance Unit.

Frequency of Verification:

Providers are generally audited every three years by MMAC, but it can vary depending on whether a complaint or allegation of fraud or other program violations are received.

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:

Private Duty Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Private Duty Nursing (PDN) is the delivery of skilled nursing services (provided by an RN or LPN) within the home. Services include assessing HIV-related illnesses which may require medical intervention, reporting changes in the client's condition to the physician, providing IV therapy, providing respiratory care including oxygen, changing dressings and caring for wounds, making referrals, and teaching family members and others about the necessary care to maintain the client at home.

Services are provided on a prior authorized basis which eliminates the duplication and overlap in services (i.e., Personal Care, Attendant Care) by not providing the same service at the same time on the same day.

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

None

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	Private Duty Nursing Agency or Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Private Duty Nursing Agency or Home Health Agency

Provider Qualifications

License *(specify):*

State Home Health Agency 197.400-475 RSMo

Certificate *(specify):*

Medicare Home Health Agency

Other Standard *(specify):*

Written proposal which specifies how provider meets regulatory requirements (13CSR 70-95.010).

Verification of Provider Qualifications

Entity Responsible for Verification:

Missouri Medicaid Audit Compliance Unit.

Frequency of Verification:

Annually

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:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies

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

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

Service Definition *(Scope):*

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

Specialized medical supplies include diapers, under-pads, and gloves.

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

None

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	Durable Medical Equipment provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Medicare certification.

Other Standard *(specify):*

Enrolled Medicaid Provider with the Missouri Medicaid Audit and Compliance (MMAC) Provider Enrollment Unit Providers must be Medicare approved prior to enrollment with MMAC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Missouri Medicaid Audit and Compliance Unit.

Frequency of Verification:

At the time of enrollment; prior to payment of service

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.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *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:

The contracted entities consist of HIV Medical Case Management agencies (includes Non-profit Community Based Organizations, Local Public Health Agencies, Universities, Hospitals, etc.) who have been contracted by DHSS to provide HIV case management services, including AIDS Waiver, to participants.

These contracted entities perform the following functions:
1) Disseminate information concerning the Waiver to potential enrollees.
2) Assist individuals in Waiver enrollment.
3) Monitor Waiver expenditures against approved levels.
4) Conduct level of care (LOC) evaluation activities.
5) Develop and reassess participant service plans.

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 agency on their employees.
Providers are responsible for requesting state criminal/background investigations on staff that provide 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 agency. The Missouri Medicaid Audit and Compliance (MMAC) Unit ensure that mandatory investigations have been conducted.

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 (explained in C-2-a). No person is allowed to be employed to work or allowed to volunteer in any capacity in any AIDS Waiver program who 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 AIDS 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. The AIDS 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.

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

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.

○ **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, 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. Medicaid enrolled providers are required to complete an addendum and submit it to MHD in order to provide AIDS Waiver services.

AIDS Waiver case managers offer participants the choice of providers as contained on the Division of Senior and Disability Services (DSDS) approved provider list.

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 States quality improvement strategy, provide information in the following fields to detail the States 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 waiver providers continuing to meet applicable licensure certification requirements. Numerator = number of waiver providers continuing to meet applicable licensure certification requirements. Denominator = Number of waiver providers enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Missouri Medicaid Audit and Compliance 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: Relicensure inspection process every two years	

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 licensed/certified new waiver providers that met enrollment criteria prior to providing services. Numerator = Number of new waiver providers that met enrollment criteria prior to providing services. Denominator = Number of new waiver providers.

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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 new non-licensed/non-certified providers that met initial waiver provider qualifications prior to providing services. Numerator= Number of new non-licensed/non-certified providers that met initial waiver provider qualifications prior to providing services. Denominator = Total number of new non-licensed/non-certified provider applicants

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

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 non-licensed/non-certified waiver providers who continue to meet waiver provider qualifications. Numerator = Number of non-licensed/non-certified waiver providers who continue to meet waiver provider qualifications. Denominator = Total number of approved providers.

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

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 providers submitting documentation that training requirements for direct care staff were met. Numerator = Number of providers submitting documentation that training requirements for direct care staff were met. Denominator = Total number of providers submitting documentation of training requirements.

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

Performance Measure:
Number and percent of new waiver providers that have someone on staff that has attended and passed provider designated manager certification. Numerator =

Number of new waiver providers that have someone on staff that has attended and passed provider designated manager certification. Denominator = Total number of new waiver providers that attended the provider designated manager certification.

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:	

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **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.

The Missouri Medicaid Audit and Compliance(MMAC)Unit, will continue to provide oversight of the providers of waiver services. MMAC Medicaid Analysts performs provider post payment reviews including care plan compliance, services billed, services provided, employee background screening and employee training.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 MHD and 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.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **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:

Waiver Participant Service Plan

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:

Masters in Social Work (MSW) or Licensed Clinical Social Worker (L.C.S.W.)

☐ **Other**
Specify the individuals and their qualifications:

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.

Development of the Waiver Participant Service Plan is a collaborative process between the Waiver case manager and each Waiver participant, which may include their families/significant others as they elect. Participants are encouraged by the Waiver case manager to participate in service plan development, and are informed of their right to involve others upon request (family, friend, partner, etc.). Participants are informed that they have a choice of who to involve in development of the service plan on the Client Choice statement. From Client Choice: I have discussed the results of the assessment with my case manager and have participated in the development of a plan for services I was offered the choice of who participates in my service plan development.

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):

The Missouri Case Management Assessment Tool (MCMAT) and HIV Level of Care (HIVLOC) include the assessment of strengths, capacities, and potential risk factors for an individual and are used to develop the Waiver Participant Service Plan (WPSP). The MCMAT is only completed once a year and the HIVLOC is completed at least twice a year. Participant's needs are assessed and evaluated based on a minimal to maximal need for assistance.

a) The WPSP is developed upon a client's initial enrollment into Waiver services. The WPSP is updated at least annually or more frequently depending on the client's status or emerging needs. The WPSP is a collaborative effort between the Waiver case manager, the client, health care team members and anyone else the client chooses to aid in WPSP development. Family members are included in WPSP development only upon client request. Service plan development takes place during home visits in the individuals residence; the Waiver case manager consults with the individual to determine convenient time for home visit.

The use of the State Plan Personal Care (SPPC)/Waiver Personal Goals and Preferences Plan (included with the SPPC/Waiver service plan) along with the SPPC/Waiver Service Plan, the HIV Level of Care assessment (HIVLOC) and the HIV Case Management Service Plan will ensure the program captures strengths, capacities, preferences and risk factors. The SPPC/Waiver Personal Goals and Preferences Plan will be used to document client strengths, personal goals, and preferences regarding relationships, community participation, employment, income and savings, healthcare and wellness, education, and mental health/substance use.

b) The HIV medical case manager completes the MCMAT to determine if the client has a need for in-home services or specialty supplies. If the client may require Waiver services, they are referred to a Waiver Case Manager for assessment using the HIVLOC. Once a referral for waiver services is completed, the SPPC/Waiver Case Manager has two days to make contact with the client to set up an appointment in the client’s home to perform the assessment. The Waiver Case Manager may also review other pertinent information prior to collaborating with the client and others to develop the WPSP. The primary goal of HIV medical case management is to establish or maintain HIV medical care. The WPSP and HIVLOC support this primary goal and allow clients to identify personal goals they may wish to pursue. The goal is to connect the client to waiver services within 30 days.

c) The Waiver Case Manager reviews the Client Choice Statement with each Waiver participant; this form is used to inform the client of his/her choices for care, and helps facilitate discussion regarding various Waiver services and provider options.

d) The MCMAT is only completed once a year and the HIVLOC is completed twice a year. The MCMAT and HIVLOC identify potential barriers to care and client identified needs and/or goals. All goals are chosen collaboratively by the Waiver Case Manager and client. The client (and family, if requested) is encouraged to offer input and voice concerns, as well as to prioritize personal goals.

e) The Waiver Case Manager is responsible for coordination of services. Waiver service providers are identified through availability and individual choice. The Waiver case manager may identify other agencies/providers who are involved in providing services to the participant and/or responsible party. Collaboration and contact with other providers is encouraged. An Authorization for Disclosure of Consumer Medical/Health Information shall be obtained to allow for exchange of information. In addition to coordinating Waiver services, Waiver case managers work to ensure that participants are receiving routine HIV medical care.

f) The Waiver Case Manager and client are responsible for implementation and monitoring of the WPSP. This is discussed during assessment, evaluation, and WPSP development.

g) The WPSP is updated annually or more frequently based on the client's status or emerging needs. Individuals and caregivers are encouraged to contact the Waiver Case Manager when changes in the plan are needed or they have concerns regarding their care and/or services.

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 process, through use of the MCMAT and HIVLOC, the Waiver case manager is able to assess potential risks based on the client's limitations and abilities. Any identified risks are discussed with the client and a plan is developed to mitigate identified risks. If the identified risks are not able to be resolved and pose an immediate threat to the safety and/or welfare of the client, Waiver services are not authorized and steps will be taken to identify an alternate arrangement for the client (may include institutional placement, family support, etc.). The WPSP is then developed to reflect the individuals personal goals as well as assessed needs in order to provide the appropriate level of waiver services. The participant selects the provider agency. Contact between the HIV medical case manager and the client assures that waiver services are appropriate to meet the goals.

Each Waiver participant and their Waiver case manager develop an emergency/back-up plan that includes but is not limited to the following:

*Steps to take if support worker fails to appear when scheduled
*Escape route from home
*Emergency contact person (including contact information)
*Contact information for police, fire, ambulance, physician, pharmacy, provider agency, etc.
*Efforts needed to mitigate any identified hazard(s)

The emergency/back-up plan is discussed and updated as needed.

Completion of the SPPC/Waiver Personal Goals and Preferences Plan form is part of the WPSP process. It is used by case managers to document and work with participants on safety concerns, including detailed plan to address each safety risk as well as a detailed emergency plan including a backup plan.

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 qualified providers is available to participants through the MO HealthNet website and is made available by the Waiver case manager upon client request. The Client Choice Statement form advises participants of their right to choose their service provider. Steps are taken to ensure that the client's preferred provider is selected when possible, though geographic coverage area and/or staffing limitations may affect the availability of a specific provider.

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 Waiver case manager completes the WPSP in collaboration with the client/representative. The WPSP is then reviewed and approved by the Regional Quality Service Manager (QSM). The WPSP is then submitted to the Waiver Program Coordinator for submission to MHD for prior authorization. The Waiver Program Coordinator receives an Authorization Determination letter from MHD. This letter is scanned into the electronic client database and the Waiver case manager and provider agency are notified of authorization.

The operating agency performs a 100% review of all records, no less than annually, on an ongoing basis to assure service plans are completed in accordance with waiver policies and procedures. Reports are provided to MHD no less than annually which document the outcome of the reviews. MHD reviews the results of that review including corrective actions and determines if any additional action is needed. As an added layer of oversite, MHD performs a separate review of 25 randomly-selected participants in addition to the statistically valid sample done by the operating agency.

All service plans are subject to the State Medicaid Agency's review and approval.

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:

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.

The client is assessed using the HIVLOC. The identified needs are used as the basis for development of the WPSP. Results from the HIVLOC are used to determine services to be provided; services and units of service are reflected on the WPSP. Additionally, Waiver case managers make referrals to non-Waiver services and discuss ongoing needs including issues regarding access to services with the client during routine contacts.

a. Monitoring the implementation of the WPSP is the responsibility of the Waiver case manager and Regional QSM. The Waiver Case Manager monitors the provision of services requested on the WPSP as well as the ongoing health and welfare of the participant.

b/c.The plan is monitored through contact by the Waiver case manager with the participant and/or provider agency. Face to face contact is made a minimum of twice every twelve(12) months (or more frequently if warranted by a change in the client's condition), with a review of the WPSP. Other contact throughout the year may be face to face, via phone or through other methods of communication. The plan is revised/updated from one (1) to twelve (12) months or as needed and rewritten a minimum of every twelve (12) months. Monitoring methods include the following:

1) Services are furnished in accordance with the WPSP. The Waiver case manager reconciles the delivered amount of services with the amount authorized upon receipt of supervisory monitoring logs from the provider agency. The supervisory monitoring log contains an explanation of any undelivered services. The QSM reviews Waiver service plans annually to ensure that services are being delivered as authorized.

2) Participants have access to Waiver services identified in the WPSP. The Waiver case manager reviews authorized Waiver services with the participant and selected provider agency prior to implementation of the WPSP. If the participant encounters problems in securing services, the Waiver case manager works with the provider agency to resolve.

3) Services meet the needs of the participant. The Waiver case manager reviews the WPSP with the participant to ensure that: services were received as authorized, services met the need, and the participant was satisfied with the services. This information is documented in the Waiver clipping encounter.

4) Emergency/Backup plans are effective. Participants contact the provider agency if a caregiver does not arrive as scheduled. Participants report missed caregiver visits to their HIV medical case manager. The emergency/back-up plan is reviewed/revised as needed.

5) Participant health and welfare is assured. During the assessment process, it is determined whether participants' health and welfare can be assured through provision of Waiver services. If participants' needs change, a reevaluation is conducted to ensure that health and welfare continue to be maintained.

6) All Waiver participant records are reviewed annually; any deficiencies that are identified during monitoring are reported as findings, and include corrective actions plans, and follow-up activities.

Monitoring of Participants' Choice of Providers:
Monitoring of participants' exercise of free choice of providers is achieved by review of the presence of a signed Client Choice Statement. This is reviewed during DHSS quarterly audits (100% audited annually), and again during MHD sampling audits.

Compilation/Reporting of monitoring results:
No less than annually MHD Program Operation's staff and DHSS Program Oversight staff meet to discuss the Quality Improvement Strategy described throughout the AIDS Waiver.

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 DHSS 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 DHSS 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 DHSS 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 DHSS and MHD. System change related to delegated activities will be the responsibility of DHSS 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 DHSS will analyze the effectiveness of system improvement activities through the Quality Improvement Strategy reports and or additional reports that may be recommended by DHSS and or MHD when significant areas of concern are identified.

As issues arise outside of the QIS, the State Medicaid Agency is in continuous contact with the operating agency through e-mail, phone and ad-hoc meetings. Issues are discussed and resolution/remediation is determined as needed. Follow-up to these issues are monitored and are also discussed at Quarterly Quality Meetings.

All reports are stratified by waiver.

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 States quality improvement strategy, provide information in the following fields to detail the States 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 participants whose service plans indicate all personal goals have been assessed and addressed in the service plan. Numerator = Number of participants whose service plans indicate all personal goals have been assessed and addressed in the service plan. Denominator = Number of participants whose service plans were reviewed.

Data Source (Select one):
Record reviews, off-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:

		Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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:

Performance Measure:
Number and percent of participants whose service plans indicate all health and safety risk factors have been assessed and addressed in the service plan. Numerator = Number of participants whose service plans indicate all health and safety risk factors have been assessed and addressed in the service plan. Denominator = Number of participants whose service plans were reviewed.

Data Source (Select one):

Record reviews, off-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: Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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:

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

Data Source (Select one):
Record reviews, off-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**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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 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 participants whose service plans were developed by qualified staff as specified in the waiver. Numerator = Number of participants whose service plans were developed by qualified staff as specified in the waiver. Denominator = Number of participants whose service plans were reviewed.

Data Source (Select one):
Record reviews, off-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:

		Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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:

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

Data Source (Select one):

Record reviews, off-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: Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants 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 participants whose service plans were updated when the participant's need changed. Numerator = Number of participants whose service plans were updated when the participant's needs changed. Denominator = Number of participants whose service plans identified a change in need.

Data Source (Select one):
Record reviews, off-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**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **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: Operating agency monitors 25% of records each quarter resulting in cumulative 100% record review annually; MHD monitors a maximum sample of 25 client 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**

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

Performance Measure:
Number and percent of participants whose service plans were reviewed/revised within one year of the most recent service plan. Numerator = Number of participants whose service plans were reviewed/revised within one year of the most recent service plan. Denominator = Number of participants whose service plans were reviewed.

Data Source (Select one):
Record reviews, off-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: Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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:

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:
 # and % of participants who received services by type, scope, amount, frequency and duration, meeting the needs of the participant identified in their service plan. Numerator= # of participants who received services by type, scope, amount, frequency and duration, meeting the needs of the participant identified in their service plan. Denominator= # of participants whose service plans were reviewed.

Data Source (Select one):
Record reviews, off-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:

		Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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:

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:
 # and % of participants with appropriately completed and signed Client Choice forms that specify choice was offered between/among waiver services and providers. Numerator = # of participants with appropriately completed and signed Client Choice forms that specify choice was offered between/among waiver services and providers. Denominator = # of participants whose records were reviewed.

Data Source (Select one):
Record reviews, off-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: Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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:

Performance Measure:
 # and % of participants with appropriately completed and signed Client Choice forms that specify choice was offered between institutional care and waiver services. Numerator = # of participants with appropriately completed and signed Client Choice forms that specify choice was offered between institutional care and waiver services. Denominator = # of participants whose records were 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: Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 States 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.

Individual problems are addressed as they are discovered. The QSM contacts the HIV medical case manager to discuss the corrective action required. If the HIV medical case manager is unable to resolve the issue, he/she will advise the QSM who will follow DHSS approved processes to determine further action required.

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:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

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.

Upon entrance into the waiver, each participant signs a Client Choice Statement which outlines the participant's right to choice of home and community-based services as an alternative to institutional care, choice of provider, and right to have others participate in the service plan process. The Waiver Case Manager informs the participant of the opportunity to request a Fair Hearing during enrollment into AIDS Waiver services. The Waiver Case Manager explains this right to the client, and reviews the Client Choice Statement form with the client; this form also explains the client's right to request a Fair Hearing, as well as the process to make such a request. All clients review and sign the Client Choice Statement prior to enrollment in AIDS Waiver services and annually thereafter. If services are to be denied, reduced or terminated, the client must be notified in writing ten days before the implementation of the change (Notification of Change Letter) of their right to a fair hearing. The Waiver Case Manager provides the notice of adverse action (Notification of Change Letter) to the client either in person or by mail; the DHSS QSM may also participate in notifying the client of any adverse action, including how to request a fair hearing. Services may be reduced or terminated immediately in the case of death, inability to be maintained safely in the home environment, Medicaid ineligibility, not diagnosed with HIV/AIDS, or due to client request.

The Client Choice Statement and Notification of Change letter outline the steps to request a fair hearing:

"I understand if my services are reduced, closed or denied, I will be advised in writing. l have the right to appeal the decision as specified in 42 Code of Federal Regulations 431.200.250. I may request a hearing within 90 calendar days of the date of this letter. I may do so by contacting the Department of Social Services, MO HealthNet Division by letter, in person or by phone. If I wish to have services continued pending the hearing decision, I MUST REQUEST THE HEARING WITHIN 10 CALENDAR DAYS OF RECEIVING THIS LETTER. I must NOTIFY MY CASE MANAGER as well as MO HealthNet of my desire before the ten day limit expires. If I request a continuation of services during my appeal and am found to be ineligible at the time of the hearing, I MAY BE RESPONSIBLE FOR ALL FEES AND CHARGES ACCRUED FOR THOSE SERVICES IN THE TIME BETWEEN REQUESTING A HEARING AND RECEIVING THE DECISION. If I request a hearing, I may present information myself or be represented by my own attorney or other persons who have knowledge of my situation. If I do not have an attorney and cannot afford one and live in an area serviced by legal aid or a legal services office, I may be eligible for free legal services. I have the right to present witnesses on my behalf and to question witnesses."

The Waiver Case Manager provides information and reviews the Client Choice Statement with the client. Depending on the client's level of function and/or literacy, the Client Choice Statement, including an explanation of the Fair Hearing process, may be read by the client, or may be explained verbally by the Waiver Case Manager. Participants can contact the Waiver Case Manager and/or DHSS if assistance is needed to complete or submit a request for a fair hearing.

Notices of all requests for Fair Hearings and actions subsequent to a Fair Hearing are maintained in the electronic client database.

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:

Missouri Department of Health and Senior Services (DHSS), Bureau of HIV, STD and Hepatitis.

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).

All agencies contracted by DHSS to provide HIV medical case management services (including Waiver) must have the following (minimum) in place:

1) Provide a clear statement to all clients of the client complaint/grievance/appeal standard, policies and procedures.
2) Provide a clear chain of command for addressing client complaint/grievance/appeal.
3) Provide an impartial, fair, and expedited review process for client complaints/grievances/appeals.
4) Delineate the mechanism and criteria whereby a client who has been dropped from case management may re-enter.
5) Describe potential outcomes of complaints/grievances/appeals procedures.

The client, caregiver, HIV medical case manager, or provider may register any grievance/complaint or inquiry/concern with DHSS, Bureau of HIV, STD, Hepatitis. A grievance/complaint may be registered at any time and whenever possible, resolution is sought through working with involved parties. An individual has a right to complain, grieve, appeal when s/he feels his/her rights have been violated. The complaint/grievance/appeal and fair hearing processes are separate and are presented as distinct processes. The client choice statement informs clients of their right to a fair hearing. Participants may request a fair hearing without following any/all steps in the complaint/grievance/appeal process.

All clients enrolled in the HIV medical case management program receive the following form which outlines the complaint, grievance, and appeal process annually:

"It is the policy of <<NAME OF AGENCY>> that you, as a client with this agency, have the right to complain, grieve, or appeal if you believe your rights have been violated. Subsequently, you have the right to be notified of the resolution of your complaint, grievance, or appeal, including any actions taken.

In every organization, differences may arise between people over the interpretation and implementation of policies and procedures. The purpose of the following procedure is to provide an effective, impartial, and expedited process to resolve differences in a manner satisfactory to all parties. All documentation related to a grievance or appeal shall be kept in a separate file for quality assurance review. There are three steps to the complaint, grievance and appeal policy as detailed below:

STEP ONE: Complaint Prior to the decision to file a formal, written grievance, the client should bring their concerns to the attention of the staff member involved in the situation to attempt to resolve the conflict. A complaint may be verbal or written, and must be logged according to agency policy whether received by phone, in person, or in writing. Upon request by either the case manager or the client, the staff members supervisor may be present for the discussion. If the situation is not resolved at this level, a written grievance can be submitted.

STEP TWO: Grievance If the situation is not resolved at the complaint level, a grievance may be submitted in order to request further review of the clients complaint. The steps of the grievance procedure are as follows:

1. Client shall describe concern in writing and submit to <<NAME OF AGENCY SUPERVISOR>>.
2. The <<NAME OF AGENCY SUPERVISOR>> will contact the client within five (5) business days of receipt of the grievance to schedule an appointment to discuss the grievance.
3. Within five (5) business days of the discussion of the grievance, a written explanation of the resolution of the grievance, including any actions taken, will be sent to the client.

Additional agency personnel may be consulted in accordance with <<NAME OF AGENCY>>s internal policies. If the resolution of the grievance is not satisfactory to you, you may file a written appeal.

STEP THREE: Appeal If the situation is not resolved at the grievance level, the client may request a secondary review of their unresolved complaint. The client must submit a written appeal to the Regional Case Management Supervisor or Quality Service Manager. A response will be sent to the client, as well as to the staff member and supervisor, within five (5) business days.

If a client feels that the above process has not adequately addressed their concerns, they have a right to file an appeal with the district health department overseeing the case management program or the Missouri Department of Health and Senior Services (DHSS). The phone numbers of those departments are:

Regional Quality Service Manager Missouri DHSS (866) 629-9891

To report abuse, neglect, or exploitation, please call DHSS at 1-800-392-0210
To file a complaint with MO HealthNet Division call 1-800-392-2161

My signature on the Client Signature Sheet reflects that I have read and understand the above complaint, grievance and appeals policy and the procedures that must be followed for filing a grievance. I have been offered a copy of these guidelines."

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/psychological abuse, financial exploitation, misappropriation of funds/property, or falsification and neglect (by self, or by others). Missouri statutes state 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). This universal mandate has no statutory penalties for not reporting, and contains no immunity for those who do report (192.2410, RSMo). 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. When any of these entities has reasonable cause to believe that a participant has been abused, neglected or exploited, they are to IMMEDIATELY after being made aware of such critical incidents, report or cause a report to be made to the department. These 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 and 192.2475, and 208.912, RSMo). The methods of reporting include calling DHSS staff or the Adult Abuse, Neglect and Exploitation Hotline 800# (this number is promoted on DHSS public information, brochure, posters, and website), making a report online at health.mo.gov/abuse, written correspondence with DHSS or through the 'Ask Us' function on DHSS' website. All reports are entered into the, APS case management 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.

Each waiver participant is provided contact information pertaining to abuse, neglect, and exploitation upon initial assessment by his/her Waiver case manager. This information is provided to the participant annually or more frequently based on the client's situation. The Waiver case manager works with each individual to ensure their understanding of what constitutes abuse, neglect, and exploitation.

Information includes: If the client feels that their rights have been violated or if they or their family has been abused, neglected or exploited, they may contact the Child Abuse or Neglect Hotline 1-800-392-3738 or the Elderly Abuse or Neglect Hotline 1-800-392-0120. Individual training and education is provided by the case manager in a culturally sensitive manner.

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. Statute 192.2415, 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 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. Reports are registered by DSDS Adult Protective Services staff into the state's APS case management system. 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 1 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. Situations described in a Class II report do not require an immediate response. DHSS staff are responsible for the investigative process. After receiving a report for investigation, DHSS staff: 1) Review the report and the prior history of any and all pertinent persons involved in the report. 2) Conduct an investigation including such steps involving medical professionals or law enforcement for urgent situations; conducting interviews (i.e., reporter, eligible adult, witnesses, and the alleged perpetrator); conducting pertinent assessments, including decisional capacity, based on reported information; collecting/gathering records, documents, and/or evidence may need to be obtained to (dis)prove the allegations in the report; and involving agencies or entities (if any) that need to be contacted to co-investigate or provide support. 3) Provide any necessary resource referrals and/or required interventions in an attempt to alleviate the eligible adult's level of risk and/or provide the eligible adult with enough support to remain in the least restrictive environment when appropriate and with the eligible adult's consent. 4) Conclude the investigation using all information obtained as well as professional observation and judgement. This will include recording all contacts and activities related to the investigation in the case record. It will also include submitting a copy of the investigation and findings to the local police, local prosecutor, or DHSS Office of General Counsel when the information gathered substantiates the allegation. A copy of the report is also sent to the DHSS Employee Disqualification List staff when a referral to this list warrants consideration. 5) Policy requires that investigations are conducted and completed and findings/results entered into the APS case management system within a ninety (90) day period. Extensions to the ninety (90) day period are allowed based on individual case circumstances. Class I reports are to be forwarded to investigative staff within one hour of receipt; class II reports are to be forwarded within 3 hours of receipt. 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 a eligible adult. The 24-hour period will begin at the time the information is received by DSDS. Investigations of Class II reports shall be initiated within a period not to exceed 48 hours after receipt of the report or by close of business the first working day after a weekend or holiday. Investigators shall conduct a face-to-face interview as soon as possible within a period not to exceed 7 calendar days from the receipt of the report. Face-to-face visits may be waived in certain situations when approved by a supervisor including when: 1) The alleged incident was previously investigated within the last 6 months and no new information was provided during the initiation process that impacts the eligible adult's health, safety, or welfare. 2) The only allegation is self-neglect and the eligible adult has been assessed face-to-face by the APS Specialist within the past six months; and has a history of refusing services with no reported decline in abilities or change in circumstances. 3) There are reports of financial exploitation involving scams or reports from financial institutions regarding fraudulent charges/transactions and no protective service needed. 4) The eligible adult cannot be located after three attempts to complete a face-to-face visit or has moved out of state. 5) The eligible adult or household member has suspected infectious illness that would pose a risk to the APS Specialist's health or safety. 6) The eligible adult has died, is inaccessible (example: eligible adult is in hospital on ventilator), or is incarcerated. 7) The eligible adult has been moved to a stable, long-term facility and safe placement, and/or the eligible adult has sufficient services in place to mitigate risks. 8) The eligible adult refuses to talk with the APS Specialist after attempt(s) to contact have been made.

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. State statutes specifically, 192.2435, 192.2500, and 192.2505, RSMo prohibit DHSS from disclosing the investigative results/reports to anyone other than the participant/legal representative upon request, the Attorney General's office to perform that office's constitutional or statutory duties, the Department of Mental Health for residents placed through that Department to perform its constitutional or statutory duties, the

appropriate law enforcement agency to perform its constitutional or statutory duties, or the Department of Social Services for individuals who receive MHD benefits to perform its constitutional or statutory duties. 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. In situations where the participant has requested to see the investigation report, contact is made with the requestor within three (3) working days notifying them of the receipt of their request. The requested information will be sent within forty-five (45) days of the notification letter or of the case closure.

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.

DSDS is responsible for overseeing the operation of the incident management system. DSDS supervisors are required to review two (2) reports per employee per month for non-probationary employees and 100% of reports for probationary employees until those employees have case approval as well as periodic reviews of all other reports. This 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. Additionally, 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, as possible, go on interviews with the investigator. The APS case management system is utilized to collect information on reports containing allegations of abuse, neglect, and/or exploitation (ANE) and to track occurrence/reoccurrence of ANE by reported adult, alleged perpetrator, and the allegation(s). This system is accessible to all investigating staff and can be utilized in the investigation process to track how similar allegations were handled in the past. DSDS is mandated to provide 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 the periodic contacts required when an individual is placed under 'protective service' status with DHSS. Person-centered protective service goals and objectives are developed and documented in the APS case management system. Participant information is collected and compiled in the APS case management system. 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), making a referral online at health.mo.gov/abuse, written correspondence with DHSS or through the 'Ask Us' function on DHSS' website. All reports are logged in the APS case management system, regardless of the method utilized to report, in order to track all reports. Information gathered on abuse, neglect, and exploitation is 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:

Facility Inspectors with DHSS are trained to complete inspections and complaint investigations in Residential Care Facilities, Assisted Living Facilities and Adult Day Care Programs. They utilize their training and skills through observation, interview, and record review (during inspections and complaint investigations) to determine whether or not restraints are being used. State regulation strictly prohibits the use of restraints except in the case of emergency. DHSS would determine if the restraint was used only after a complete assessment and care planning. DHSS would also ensure that only the least restrictive restraint has been used and is appropriate for the individual resident to attain or maintain his or her highest practicable physical and psychosocial well-being. DHSS would also ensure the facility has the ability to monitor the restraint, to ensure the program continues to assess the care plan and the restraint use on an ongoing basis.

Suspected inappropriate use of restrictive interventions would be reported to and investigated by the Abuse and Neglect Hotline.

State regulation strictly prohibits the use of restraints except in the case of emergency. As part of an onsite investigation, DHSS would first determine if an emergency existed and then determine if the least restrictive restraint was used by reviewing the complete assessment of the individual and interviewing persons involved regarding how they determined it was the least restrictive restraint. Through observation, interview and record review, the State would ensure that the use of the restraint was not for the purpose of discipline or convenience and the physician determined that the circumstances were such that an emergency existed. Facility inspectors are trained by the same guidelines as our long term care surveyors for skilled nursing facilities. In Residential Care Facilities, state law prohibits (except in the case of emergency) residents to be inhibited by chemical and/or physical restraints that would limit self-care or ability to negotiate a path to safety unassisted or with assistive devices. Since the only allowance for their use is in the event of an emergency, DHSS Section for Long-term Care Regulation (SLCR) staff would review facility policy and procedures related to the emergency use of restraints to ensure they include provisions for physician notification prior to its use, responsible party notification, specific details of what constitutes an emergency that would warrant the use, the disciplines of staff who are trained in the safe application of the restraint to be used, how facility staff will provide monitoring while additional staff are assisting the resident to receive the needed emergency medical attention he/she needs, and the criteria for when the restraint should be discontinued (the emergency passes). SLCR inspectors would question facility staff in relation to their knowledge of these emergency policy and procedures to ensure they have a clear understanding.

○ **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).

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:

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:

Facility Inspectors with DHSS are trained to complete inspections and complaint investigations in Residential Care Facilities, Assisted Living Facilities and Adult Day Care Programs. They utilize their training and skills and through observation, interview and record review (during inspections and complaint investigations) to determine whether or not restraints are being used. State regulation strictly prohibits the use of restraints except in the case of emergency. DHSS would determine if the restraint was used only after a complete assessment and care planning. DHSS would also ensure that only the least restrictive restraint has been used and is appropriate for the individual resident to attain or maintain his or her highest practicable physical and psychosocial well-being. DHSS would also ensure the facility has the ability to monitor the restraint, to ensure the program continues to assess the care plan and the restraint use on an ongoing basis.

Suspected inappropriate use of restrictive interventions would be reported to and investigated by the Abuse and Neglect Hotline.

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 our licensing regulations; however, they do address each piece of the definition in their 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 seclusion. Participant rights may not be restricted by the program and they include protections from physical/chemical restraints, seclusion, interference, coercion, discrimination and reprisal

As indicated previously under restraints, State regulation strictly prohibits the use of restraints except in the case of emergency. As part of an onsite investigation, DHSS would first determine if an emergency existed and then determine if the least restrictive restraint/intervention was used by reviewing the complete assessment of the individual and interviewing persons involved regarding how they determined it was the least restrictive restraint/intervention. Through observation, interview and record review, the State would ensure that the use of the restraint/intervention was not for the purpose of discipline or convenience and the physician determined that the circumstances were such that an emergency existed. Facility inspectors are trained by the same guidelines as our long term care surveyors for skilled nursing facilities.

Resident care must be provided in a manner and with sufficient safeguards to ensure the safety, welfare and rights of the resident and in accordance with the therapeutic goals for the resident.

In Residential Care Facilities, state law prohibits (except in the case of emergency) residents to be inhibited by chemical and/or physical restraints that would limit self-care or ability to negotiate a path to safety unassisted or with assistive devices. Restricting an individual's access to other individuals, locations or activities is considered seclusion. Participant rights may not be restricted by the facility and these rights include protections from physical/chemical restraints, seclusion, interference, coercion, discrimination and reprisal.

Since the only allowance for the use of restraint/intervention is in the event of an emergency, SLCR staff would review facility policy and procedures related to the emergency use of restraints to ensure they include provisions for physician notification prior to its use, responsible party notification, specific details of what constitutes an emergency that would warrant the use, the disciplines of staff who are trained in the safe application of the restraint/intervention to be used, how facility staff will provide monitoring while additional staff are assisting the resident to receive the needed emergency medical attention he/she needs, and the criteria for when the restraint/intervention should be discontinued (the emergency passes). SLCR inspectors would question facility staff in relation to their knowledge of these emergency policy and procedures to ensure they have a clear understanding.

○ **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.

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:

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:

All waiver services are performed in the participant's home with the exception of Attendant Care at Cooper House (Doorways), which is a Residential Care Facility II. The SPPC/Waiver Case Manager makes a minimum of quarterly contact with the participant as well as face-to face visits bi-annually. The suspected inappropriate us of restraints or seclusion would be detected through assessment, observation and communication. SPPC/Waiver Case Managers are mandated reporters and would report any suspicion of restraint or seclusion. Suspected inappropriate use of restraints or seclusion would be documented and reported to the Central Registry Unit at the Department of Health and Senior Services (DHSS) if abuse, neglect or exploitation is identified.

The MO HealthNet AIDS Waiver Manual, section 13.3.A Participant's Rights, states each provider shall have a written statement of the participant's rights which is to be given to each participant or parent(s) responsible party(ies) at the time of service is initiated and which includes, at a minimum, the right to: be treated with respect and dignity; have all personal and medical information kept confidential; have direction over the services provided, to the degree possible, within the service plan authorized; know the provider's established grievance procedure, how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution; know the procedure to report abuse, neglect, or exploitation; receive service without regard to race, creed, color, age, sex or national origin; and receive a copy of the written statement of the participant's rights.

According to the DHSS Division of Regulation and Licensure for Long Term Care, Licensure Regulations Manual (includes Residential Care Facility I & II), involuntary seclusion means a separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates)against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and 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 resident's needs.

Furthermore, 19 CSR 30-88.010 Resident Rights establishes requirements for protection of resident rights in all types of licensed long term care facilities. According to this rule, the exercise of resident rights shall be free from restraint, interference, coercion, discrimination or reprisal. Each resident shall be free from abuse. Abuse is the infliction of physical, sexual, or emotional injury or harm and includes verbal abuse, corporal punishment, and involuntary seclusion. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. The facility shall ensure all staff are trained on the applicable laws and rules regarding reporting of suspected abuse and neglect of any resident. If the administrator or other employee of a long-term care facility has reasonable cause to believe that a resident of the facility has been abused or neglected, the administrator or employee shall immediately report or cause a report to be made to the department. Any administrator or other employee of a long-term care facility having reasonable cause to suspect that a vulnerable person has been subjected to abuse or neglect or observes such a person being subjected to conditions or circumstances that would reasonably result in abuse or neglect shall immediately report or cause a report to be made to DHSS and to the Department of Mental Health.

○ **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).

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:

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.

Any entity providing Waiver services that dispenses medication maintains ongoing responsibility for monitoring of participant medication regimens, including dispensing of medications/treatments for participant self-administration. All Assisted Living Facilities are subject to monitoring and inspection by DHSS' Division of Regulation and Licensure (DRL). Annually, DRL conducts one (1) complete site visit, one (1) interim site visit (typically at the six month point), and additional periodic site visits as needed or if prompted by a complaint. During these site visits, DRL reviews records regarding medication management and dispensing. Additionally, DRL directly observes how medications and treatments are dispensed by the Assisted Living Facility provider. This observation includes a review of medications dispensed,and review of provider's observation of patients to ensure that medications are taken properly or that treatments (ex: inhaler, insulin, etc.) are completed properly by the patient or with direct instruction and assistance by staff. Any deficiencies will result in DRL issuing a finding against the Assisted Living Facility which, depending on the severity, would either be corrected immediately, result in an action plan, or result in an unsatisfactory site visit and any needed actions by DRL.

Monitoring/oversight methods are not the same for participants residing in their own home and receiving provider assistance.

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.

DHSS is the agency responsible for the licensing of long term care facilities in the state of MO. Each long term care facility is required to be inspected to ensure they are complying with state regulations pertaining to their licensure level. Included in the Administration and Resident Care Requirements, are regulations that pertain to the management of medications.

In an RCF*, each facility is required to ensure they have a licensed nurse employed by the facility to work at least eight (8) hours per week at the facility for every thirty (30) residents or additional major fraction of thirty (30). The nurse's duties include, but are not limited to, review of resident's charts, medications and special diets or other orders, review of each resident's adjustment to the facility and observation of each individual resident's general physical and mental condition. The nurse is to inform the administrator of any problems noted and they are to be brought to the attention of the resident's physician. Each facility is required to develop and implement a safe and effective system of medication control and use which assures that all residents medications are administered or distributed by personnel at least eighteen (18) years of age, in accordance with physicians instructions using acceptable nursing techniques.

Additionally, a pharmacist or registered nurse is required to review the drug regimen of each resident, at least every other month in a facility. The review is to be performed in the facility and shall include, but shall not be limited to, possible drug and food interactions, contraindications, adverse reactions and a review of the medication system utilized by the facility. Irregularities and concerns are to be reported in writing to the resident's physician and to the administrator. If after thirty (30) days, there is no action taken by a resident's physician and significant concerns continue regarding a residents or residents medication order(s), the administrator shall contact or re-contact the physician to determine if he or she received the information and if there are any new instructions.

If any problems are noted in the area of medication administration during the inspection through record review, interview and observations, the facility is advised of the deficient area and provided with a Statement of Deficiency that outlines the deficient practice. Each facility is required to provide a Plan of Correction to outline how they will accomplish correcting the citation. DHSS performs revisits to ensure corrective action has been taken by the facility.

MHD has access to the Automated Survey Processing Environment (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) 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 regard to license denial or revocation.

DHSS regional office staff and central office staff monitor facilities to ensure they achieve substantial compliance through submission of plans of correction and revisits. DHSS provides long term care providers with data regarding frequent trends in citations and also assists to provide training during annual provider meetings on current topics/issues.

Monitoring/oversight methods are not the same for participants residing in their own home and receiving provider assistance.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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).

Self-control of prescription medication by a resident may be allowed only if approved in writing by the resident's physician and allowed by facility policy. If a resident is not taking any prescription medication, the resident may be permitted to control the storage and use of nonprescription medication unless there is a physician's written order or facility policy to the contrary. If not permitted, all medications for that resident, including over the counter medications, shall be controlled by the administrator unless the physician specifies otherwise. Written approval for self-control of prescription medication shall be rewritten as needed but at least annually and after any period of hospitalization. All medications are to be safely stored at proper temperature and shall be kept in a secured location behind at least one (1) locked door or cabinet. If access is controlled by the resident, a secured location shall mean in a locked container, a locked drawer in a bedside table or dresser or in a resident's private room if locked in his/her absence, although this does not preclude access by a responsible employee of the facility.

All residents medications are required to be administered or distributed by personnel at least eighteen (18) years of age, in accordance with physicians instructions using acceptable nursing techniques. Those facilities administering medications shall utilize personnel trained in medication administration (a licensed nurse, certified medication technician or level I medication aide).

Any one administering medication has to be 18 years or older and be a level I medication aide, certified medication technician,licensed nurse,or physician. Employee personnel records include experience and education including documentation of specialized training on medication and/or insulin administration. During an inspection/complaint, if the facility is not complying with one of SLCR’s regulations a citation can be issued depending on the outcome of the inspection.

Monitoring/oversight methods are not the same for participants residing in their own home and receiving provider assistance.

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:

The administration or distribution of medication shall be recorded on a medication sheet or directly in the resident's record and, if recorded on a medication sheet, shall be made part of the resident's record. The administration or distribution shall be recorded by the same person who prepares the medication and who distributes or administers it.
All medication errors and adverse reactions shall be promptly documented and reported to the facility's administrator and the resident's physician. If the pharmacy made a dispensing error, it is also to be reported to the issuing pharmacy. If during an inspection or complaint investigation, DHSS requests information/documentation, the facility is required to provide any documentation requested.

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.

SLCR is responsible for licensing long term care facilities and through the inspection process monitors administration of medication. DHSS monitoring of Waiver providers is identical to the monitoring of any other long term care provider and a provider's provision of Waiver services would not require any additional or specialty monitoring from SLCR. Standard monitoring activities for Waiver and other providers include observation of medication pass, review of physician orders, etc. DHSS performs these tasks during each inspection process. Currently inspections are completed at a minimum of upon initial licensure and then within 6 months of each facilities' relicensure. Facilities are required to reapply for a license every 2 years.

MHD 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 SODs 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 regard to license denial or revocation.

DHSS regional office staff and central office staff monitor facilities to ensure they achieve substantial compliance through submission of plans of correction and revisits. DHSS provides long term care providers with data regarding frequent trends in citations and also assists to provide training during annual provider meetings on current topics/issues.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
 # & % of participants whose records indicate participant, family or guardian received information/education on how to report abuse, neglect, exploitation(ANE) and unexplained deaths. Num= # of participants whose records indicate participant, family or guardian received information/education on how to report ANE and unexplained deaths. Den= # of participants whose records were reviewed.

Data Source (Select one):
Record reviews, off-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:

		Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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:

Performance Measure:
Number and percent of participants whose records document the participant has a back-up plan that is subject to the participant's needs and preferences. Numerator = Number of participants whose records document the participant has a back-up plan that is subject to the participant's needs and preferences. Denominator = Number of participants whose records were reviewed.

Data Source (Select one):

Record reviews, off-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: Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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:

Performance Measure:
 # and % of participants whose records document the participant and/or family or legal guardian was provided information on who to contact regarding complaints. Numerator = Number of participants whose records document the participant and/or family or legal guardian was provided information on who to contact regarding complaints. Denominator = Number of participants whose records were reviewed.

Data Source (Select one):
Record reviews, off-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: Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of hotline investigations regarding substantiated allegations of abuse, neglect, exploitation (ANE) resulting in referral/safety plan to prevent future occurrences. Num = # of hotline investigations regarding substantiated allegations of ANE resulting in referral/safety plan to prevent future occurrences. Den = # hotline investigations regarding substantiated allegations of ANE.

Data Source (Select one):
Critical events and incident reports
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:

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 hotline reports resulting in investigation that were initiated within required timeframes. Numerator = Number of hotline reports resulting in investigation that were initiated within required timeframes. Denominator = Number of hotline reports resulting in investigation that were reviewed.

Data Source (Select one):
Critical events and incident reports
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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of hotline reports resulting in investigation that were closed within required timeframes. Numerator = Number of hotline reports resulting in investigation that were closed within required timeframes. Denominator = Number of hotline reports resulting in investigation that were reviewed.

Data Source (Select one):
Critical events and incident reports
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 medication errors or adverse reactions that were documented and reported to the facility administrator and the resident's physician. Numerator = Number of medication errors or adverse reactions that were documented and reported to the facility administrator and the resident's physician. Denominator = Number of medication errors or adverse reactions that occurred.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data from Division of Regulations and Licensure

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Number and percent of hotline investigations regarding unexplained deaths of waiver participants reviewed within required timeframes. Numerator = Number of hotline investigations regarding unexplained deaths of waiver participants reviewed within required timeframes. Denominator = Number of hotline investigations regarding unexplained deaths of waiver participants 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 =
☐ **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 participants whose records indicate they were informed that restraints and seclusion are not allowed in the waiver. Numerator = Number of participants whose records indicate they were informed that restraints and seclusion are not allowed in the waiver. Denominator = Number of participants whose records were reviewed.

Data Source (Select one):
Record reviews, off-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:
	☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:

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:
 # and % of participants whose records indicate the State monitored for instances of restrictive interventions and/or seclusion during annual site visits. Numerator = # of participants whose records indicate the State monitored for instances of restrictive interventions and/or seclusion during annual site visits. Denominator = # of records reviewed.

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

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(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 =
☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 waiver participants who received the appropriate routine HIV medical care. Numerator = Number of waiver participants who received the appropriate routine HIV medical care. Denominator = Number of waiver participants reviewed.

Data Source (Select one):
Record reviews, off-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: Operating agency will review one-quarter of Waiver records per quarter, resulting in a cumulative 100% record review 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of participants whose service plans address their health needs.
Numerator = Number of participants whose service plans address their health needs.
Denominator = Number of participants whose service plans were 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:
	☐ **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 States 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.

The QSM addresses any issues with the Waiver case manager related to health, welfare and safety immediately. Any occurrences relating to health, welfare and safety concerns are documented on a Quality Assurance (QA) report that is submitted to the QSM. The QSM forwards the QA report to the Director of HIV Case Management for review, analysis and aggregation. Upon identification or notification of individual problems, the QSM makes contact with the appropriate Waiver case manager and/or that individuals agency supervisor. The QSM outlines the steps that need to be taken to resolve the issue, including timeframes, responsible parties and required follow-up for any and all steps of the remediation process. If the QA report indicates that further action is required in order to remediate the individual issue, the Director of HIV CM will outline the steps that need to be taken to resolve the issue, including timeframes, responsible parties and required follow-up for any and all steps of the remediation process. If the QA report was submitted for an issue that has been successfully remediated, the Director of HIV CM will notify MHD and provide a copy of the QA report for inclusion in MHD reporting. The Director of HIV CM also reviews QA reports for trends and works to identify system/process improvements that can be made to avoid future problems.

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 3)

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; and
- 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 3)

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 Operations 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), Structured Family Caregiving Waiver (1706), Medically Fragile Adult Waiver (40190), Brain Injury Waiver (1406) and Structured Family Caregiving Waiver (1706).

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 DHSS 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 DHSS 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.

System improvement activities related to participant health, welfare, and safety are the first priority for MHD and DHSS 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 DHSS and MHD. System change related to delegated activities will be the responsibility of DHSS 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 DHSS will analyze the effectiveness of system improvement activities through the Quality Improvement Strategy reports and or additional reports that may be recommended by DHSS 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

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each 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 DHSS 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 waiver is evaluated and updated no less than annually by MHD and DHSS. The process includes the review of performance measures, reports for performance measures and remediation activities resulting from discovery. Annually MHD and DHSS 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 process is working. If it is determined additional input is necessary, DHSS and MHD will request input from individuals involved in the authorization and/or delivery of waiver services. This could include providers and/or DHSS and MHD staff from other units within the Divisions.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

There are two surveys that inquire about quality of life that are given yearly to AIDS Waiver participants. The first survey used is titled Home and Community Based Services Participant Survey. This survey specifically targets questions about the agency from which the client is receiving services and the overall wellbeing of the client. There are two variations of this survey, one with home health agencies that provide services, and another specifically for Doorways Supportive Housing. The second survey, titled AIDS Waiver Client Survey, inquires about how the client views their case management services, if the services they are receiving are helping them remain in the home, and if the client's needs are being met.

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 AIDS Waiver must be prior authorized by state staff; prior authorizations are based on the agreed upon services established during the service planning process. The authorized services are forwarded to MO HealthNet's fiscal agent. A copy of the authorization is also provided to the provider selected by the waiver participant; therefore, the provider is aware of the authorization level. The authorization in MMIS contains the waiver specific procedure code and the number of units authorized per month for the participant. No reimbursement will be made for units billed by the provider in excess of the authorized amount. Each date of service must match or fall within the from/through dates on the appropriate line of the authorization. Each time a claim is processed and paid, the number of units reimbursed to the provider is deducted from the number of units authorized. Claims submitted by the provider are subjected to edits in MMIS to ensure that payment is made only on behalf of those consumers who are MO HealthNet eligible and to providers who are enrolled on the date a service is delivered. 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.

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.

Review results statistics are available upon request.

Providers have the responsibility of ensuring they have adequate documentation to support the Bureau of HIV, STD and Hepatitis (BHSH) 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 BHSH 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 BSHS database in order to electronically submit the prior authorization information to MMIS.

BHSH' 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 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 DHSS' database. MMAC personnel are also independently able to verify employees' registration and screening through the FCSR. However, MMAC expects the providers to have access to 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 States quality improvement strategy, provide information in the following fields to detail the States 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 waiver claims paid for services that are included in the approved waiver. Numerator = Number of waiver claims paid for services included in the waiver. Denominator = Total number of 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 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, within a representative sample, whose claims were reviewed that had supporting documentation of services rendered. Numerator = Number of providers, within a representative sample, whose claims were reviewed that had supporting documentation of services rendered. Denominator = Number of providers in the sample.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Provider Monitoring 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:*

Performance Measure:

Number and percent of waiver claims paid that were prior authorized. Numerator = Number of waiver claims paid that were prior authorized. Denominator = Total number of waiver claims paid.

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***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***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:
Number and percent of waiver rates paid that adhere to the rate methodology specified in the waiver application. Numerator = Number of waiver rates that adhere to the rate methodology specified in the waiver application. Denominator = Total number of waiver rates 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:*

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 States 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 responsiblity 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 AIDS Waiver are subject to and determined by the State Legislature, through the State of Missouri 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.

Participants and business entities are able to testify at annual appropriation hearings conducted by the State House of Representatives and State Senate appropriation committees to provide input on reimbursement rates.

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 AIDS Waiver services and the Consumer Price Index. The state legislature has the opportunity to ask questions from state agencies during the appropriations process. The historical data used to establish these rates have not been maintained and is not available.

Rates are reviewed annually during each legislative session (January - May) by the state legislature. The legislature makes the decision regarding any updates at this time.

The rates established by the Missouri Legislature are statewide rates; it does not vary by provider. Current reimbursement rates can be found on the MO HealthNet 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.

The historical data used to establish these rates have not been maintained and is not available. 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 AIDS Waiver are based on historical state plan and waiver rates, are part of the core budget and have been adjusted over the years as funding is appropriated by the State Legislature. Current rates remain sufficient to ensure access to quality of care as there is provider competition for service, and there is a lack of participant complaints regarding inability to select/find a provider, and lack of participant complaints regarding quality of care.

Funding for waiver services includes funding from the temporary 10 percentage point increase to the FMAP for Medicaid expenditures for home and community-based services provided under section 9817 of the American Rescue Plan Act of 2021 (ARP). Utilization of ARP funding will continue until all funds are exhausted, at which time funding of the State match will switch to all State general/tax revenue.

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). The prior authorization is forwarded to the Medicaid Fiscal Agent. Providers of services bill claims for services directly to the Medicaid 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.

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.

- (●) ***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.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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 home and community based appropriations belong to the DHSS. 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:*

Rates for Supportive Living services provided in an Assisted Living Facility (ALF) do not include room and board charges. Providers must establish separate rates for Room and Board costs. Room and Board is billed through separate procedure codes on a separate invoice from that of waiver Supportive Living attendant care services. No Federal Financial Participation (FFP) funding is used for room and board. All rates are carefully reviewed to ensure that room and board costs are separated and are not claimed for FFP.

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	33712.21	37283.16	70995.37	86508.54	44269.96	130778.50	59783.13
2	37530.03	38289.80	75819.83	88844.27	45465.25	134309.52	58489.69

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)
3	41770.44	39323.63	81094.07	91243.06	46692.82	137935.88	56841.81
4	44519.71	40385.36	84905.07	93706.63	47953.52	141660.15	56755.08
5	44579.35	41475.77	86055.12	96236.71	49248.27	145484.98	59429.86

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	161	161
Year 2	161	161
Year 3	161	161
Year 4	168	168
Year 5	186	186

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 is 283 days. This number is based on the total waiver days of service (21527 days) divided by the total number of waiver participants (76 participants) in waiver year November 1, 2019 through October 31, 2020.

The data used to estimate the average length of stay is from the 372 report for the waiver year November 1, 2019 through October 31, 2020.

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 and methodology for these estimates is as follows:*

Factor D is projected based on the 372 Report and historical data for Waiver Years 2014-2019 for waiver personal care and waiver attendant care; and WYs 2015-2019 was used for specialized medical supplies, as 2014 was an outlier.

Waiver Personal Care: Trended forward from WY 2019 utilizing a 2% multiplier in users and an average annual increase in units of 7%. With the 2022 rate increase, the average annual rate increase calculates to be 5%. However, the State is choosing to use the FY22 2% market basket rate due to the rate increases after the COVID-19 pandemic. The State anticipates the reimbursement rates will level out, therefore, chose to use the market basket rate rather than historical projections. Using these average annual increases, the average cost per user was projected forward through WY 2027. This was figured by multiplying the projected average annual users by projected unit rate, and multiplying that by projected average annual units.

Specialized Medical Supplies: Trended forward from WY 2019 based on an average annual increase in users of 7%; an average annual utilization of 10 units; and annual rate increase of 2%. Using those average annual increases, the average cost per user was projected forward through WY 2027. This was figured by multiplying the projected average annual users by projected unit rate, and multiplying that by projected average annual units.

Waiver Attendant Care: Trended forward from WY 2019 utilizing average annual increase in users of 7% and an average annual increase in units of 7%. With the 2022 rate increase, the average annual rate increase calculates to be 8%. However, the State is choosing to use the FY22 2% market basket rate due to the rate increases after the COVID-19 pandemic. The State anticipates the reimbursement rates will level out, therefore, chose to use the market basket rate rather than historical projections. Using these average annual increases, the average cost per user was projected forward through WY 2027. This was figured by multiplying the projected average annual users by projected unit rate, and multiplying that by projected average annual units.

Private Duty Nursing: There was no utilization of Private Duty Nursing services during the waiver period of 2017-2020; therefore, there is no utilization estimated for the waiver period of 2022-2027. The State would like to keep this service in the waiver so it can continue to be available to waiver participants in the event it is needed.

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 WY 2020 at the FY 22 market basket rate of 2.7%. The WY 2020 D' value is $34,419.25. 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 from WY 2020 at the FY 22 market basket rate of 2.7% using actual 2020 expenditures for residents of Hope Care, an HIV/AIDS only facility enrolled under 13 CSR 70-10.080. The WY 2020 Factor G value was $79,863.37.

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 from WY 2020 at the FY 22 market basket rate of 2.7% using state plan services provided to residents of Hope Care, an HIV/AIDS only facility enrolled under 13 CSR 70-10.080. The WY 2020 Factor G' value was $40,869.36. 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	
Waiver Personal Care	
Attendant Care	
Private Duty Nursing	
Specialized Medical Supplies	

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
Waiver Personal Care Total:						481955.44
Waiver Personal Care	15 MINUTES	17	3644.00	7.78	481955.44	
Attendant Care Total:						4917150.00
Attendant Care	PER DIEM	63	223.00	350.00	4917150.00	
Private Duty Nursing Total:						0.00
Private Duty Nursing	15 MINUTES	0	0.00	0.01	0.00	
Specialized Medical Supplies Total:						28560.00
Specialized Medical Supplies	PER MONTH	60	10.00	47.60	28560.00	
GRAND TOTAL:						5427665.44
Total Estimated Unduplicated Participants:						161
Factor D (Divide total by number of participants):						33712.21
Average Length of Stay on the Waiver:						283

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
Waiver Personal Care Total:						557245.08
Waiver Personal Care	15 MINUTES	18	3899.00	7.94	557245.08	
Attendant Care Total:						5453532.00
Attendant Care	PER DIEM	67	228.00	357.00	5453532.00	
Private Duty Nursing Total:						0.00
Private Duty Nursing	15 MINUTES	0	0.00	0.01	0.00	
Specialized Medical Supplies Total:						31557.50
Specialized Medical Supplies	1 MONTH	65	10.00	48.55	31557.50	
			GRAND TOTAL:			6042334.58
			Total Estimated Unduplicated Participants:			161
			Factor D (Divide total by number of participants):			37530.03
			Average Length of Stay on the Waiver:			283

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
Waiver Personal Care Total:						608277.60
Waiver Personal Care	15 MINUTES	18	4172.00	8.10	608277.60	
Attendant Care Total:						6082594.56
Attendant Care	PER DIEM	72	232.00	364.14	6082594.56	
Private Duty Nursing Total:						0.00
Private Duty Nursing	15 MINUTES	0	0.00	0.01	0.00	
Specialized Medical Supplies Total:						34168.80
Specialized Medical					34168.80	
			GRAND TOTAL:			6725040.96
			Total Estimated Unduplicated Participants:			161
			Factor D (Divide total by number of participants):			41770.44
			Average Length of Stay on the Waiver:			283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supplies	1 MONTH	69	10.00	49.52		
			GRAND TOTAL:			6725040.96
			Total Estimated Unduplicated Participants:			161
			Factor D (Divide total by number of participants):			41770.44
			Average Length of Stay on the Waiver:			283

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 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 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Personal Care Total:						663707.52
Waiver Personal Care	15 MINUTES	18	4464.00	8.26	663707.52	
Attendant Care Total:						6778226.07
Attendant Care	PER DIEM	77	237.00	371.43	6778226.07	
Private Duty Nursing Total:						0.00
Private Duty Nursing	15 MINUTES	0	0.00	0.01	0.00	
Specialized Medical Supplies Total:						37377.40
Specialized Medical Supplies	1 MONTH	74	10.00	50.51	37377.40	
			GRAND TOTAL:			7479310.99
			Total Estimated Unduplicated Participants:			168
			Factor D (Divide total by number of participants):			44519.71
			Average Length of Stay on the Waiver:			283

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 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 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Personal Care Total:						764224.46
Waiver Personal Care	15 MINUTES	19	4777.00	8.42	764224.46	
Attendant Care Total:						7486833.70
Attendant Care	PER DIEM	82	241.00	378.85	7486833.70	
Private Duty Nursing Total:						0.00
Private Duty Nursing	15 MINUTES	0	0.00	0.01	0.00	
Specialized Medical Supplies Total:						40700.80
Specialized Medical Supplies	1 MONTH	79	10.00	51.52	40700.80	

GRAND TOTAL:	8291758.96
Total Estimated Unduplicated Participants:	186
Factor D (Divide total by number of participants):	44579.35
Average Length of Stay on the Waiver:	283