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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

Request for 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:
Independent Living Waiver

C. Waiver Number:MO.0346
Original Base Waiver Number: MO.0346.90.01

D. Amendment Number:

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/17

Approved Effective Date of Waiver being Amended: 04/26/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Missouri is changing eligibility standards for Nursing Facility Level of Care. Currently, potential participants must obtain 21 points in order to qualify. Missouri is increasing the point count required to qualify for Nursing Facility Level of Care in state regulation at 19 CSR 30-81.030. This amendment is to revise this waiver application to reflect the change in Nursing Facility Level of Care requirements.

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 Application**	Main Att. 1 & 2
☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	3.f.6.d.
☑ **Appendix C – Participant Services**	5.

Component of the Approved Waiver	Subsection(s)
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☑ Appendix J – Cost-Neutrality Demonstration	2.c., 2.d.i.

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:
Raise Level of Care, and update potential waiting list entrance protocol

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*):
Independent Living 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.0346
Draft ID: MO.004.03.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/14
Approved Effective Date of Waiver being Amended: 04/26/14

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.
Purpose: The Independent Living Waiver was developed to provide community-based alternatives to physically disabled individuals 18 years of age and above who otherwise would be institutionalized in a nursing facility.

Goal: Establish and maintain a community-based system of care of individuals 18 years of age and over who have physical disabilities that live and wish to continue living independently in their homes and/or communities.

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

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

Service Delivery Methods: DSDS staff prior authorizes waiver services. Services are delivered through providers who have a participation agreement (contract) with the Department of Social Services, Missouri Medicaid Audit and Compliance Unit (MMAC) as an Independent Living Waiver (ILW) provider. Waiver services are prior authorized and claims for reimbursement are filed directly with the Medicaid Management Information System (MMIS) fiscal agent for processing and payment. MHD reimburses enrolled waiver providers directly.

3. Components of the Waiver Request

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

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

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
Comments and recommendations are obtained from/through: Missouri Statewide Independent Living Council, participant feedback, DSDS staff, MMAC Quality Review staff, and other stakeholders, in addition to other state agencies to seek input into the development and implementation of the waiver.

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: 615 Howerton Court

Address 2: PO Box 6500

City: Jefferson City

State: **Missouri**

Zip: 65102-6500

Phone: (573) 751-9290 **Ext:** ☐ **TTY**

Fax: (573) 526-4651

E-mail: Glenda.A. Kremer@dss.mo.gov

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

Last Name: Garber

First Name: Bobbi Jo

Title: Director

Agency: Department of Health and Senior Services, Division of Senior and Disability Services

Address: 912 Wildwood

Address 2: PO Box 570

City: Jefferson City

State: **Missouri**

Zip: 65102-0570

Phone: (573) 526-3626 **Ext:** ☐ **TTY**

Fax: (573) 751-8687

E-mail: Bobbi.jo.garber@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: Corsi

First Name: Steve

Title: Psy.D, Acting Director

Agency: Department of Social Services, MO HealthNet Division

Address: 615 Howerton Court

Address 2:

City: Jefferson City

State: Missouri

Zip: 65101

Phone: (573) 751-6922 Ext: TTY

Fax: (573) 751-6564

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

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the

state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that the settings transition plan included with this waiver will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Missouri administers Home and Community-Based Waivers through the single State Medicaid agency, the Department of Social Services, MO HealthNet Division (MHD). The day-to-day operation of the Waiver is through a formal cooperative agreement with the Missouri Department of Health and Senior Services (DHSS). The Department of Health and Senior Services is the operational entity for the waiver. Missouri Medicaid Audit and Compliance (MMAC) is the unit within the Department of Social Services (DSS) charged with administering and maintaining Medicaid Title XIX audit and compliance initiatives, including utilization of Medicaid services and provider enrollment functions. MMAC will participate in the transition plan as described below.

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

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

• Adult Day Care Waiver (MO.1021)
o All services in the Adult Day Care Waiver (ADCW) are received and administered in an Adult Day Care. The ADCW provides adult day care for individuals age 18-63 with physical and other disabilities. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

• Aged and Disabled Waiver (MO.0026)
o All services in the Aged and Disabled Waiver (ADW) are received and administered in the participant's home or in an Adult Day Care. The ADW provides adult day care, basic respite care, homemaker services, advanced block respite care, advanced daily respite care, advanced respite care, basic block respite care, chore services, home delivered meals, nurse respite for aged individuals ages 65 and over and for those who are physically disabled ages 63 and 64. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

• AIDS Waiver (MO.0197)
o The services in the AIDS waiver are received and administered in the participant's home, except attendant care which is provided in a residential care facility (Doorways/Cooper House). The AIDS waiver provides attendant care, private duty nursing, personal care, and supplies for individuals who are HIV positive and age 21 or over. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment and with whom to interact.

• Independent Living Waiver (MO.0346)
o All services in the Independent Living Waiver (ILW) are received and administered in the participant's home. The ILW

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

• Medically Fragile Adult Waiver (MO.40190)
o All services in the Medically Fragile Adult Waiver are received and administered in the participant's home. The Medically Fragile Adult Waiver provides private duty nursing, waiver attendant care, and specialized medical supplies. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

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

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

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

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

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

• Section 1: Assessment: This amended STP provides more detail on the following components:
o General Settings categories with estimated number of settings falling under each category
o Determination of Heightened Scrutiny settings,
o Assessment tool development,
o Systemic Initial On-Site Assessment process including amounts and process of on-site assessments performed,
o On-going monitoring through incorporating the HCBS requirements into existing quality integrated functions, and
o Provider self-assessment and participant survey development.

• Section 2: Remediation Strategies: This amended STP provides more detail on the following components: o Code of State Regulations Review and Rule filing, including a crosswalk to the HCBS final rule,
o Incorporating HCBS final rule into
• Provider Manuals and Provider Enrollment processes,
• provider meetings and trainings;

• processes for provider remediation and status updates,
• on-going compliance reviews, provider sanctions; and
• individuals transitioning to settings that align with HCBS Requirements

• Section 3: Public Comment: This amended STP provides more detail on the following components:
o Incorporating new public comment processes and periods

Section 1: Assessment
The State used a multi-faceted approach to assessment. This approach included a review of state regulations, policies, procedures, provider manuals, enrollment processes and tools, provider review processes and quality review tools. It also included the development and completion of a settings analysis, provider self-assessment and participant survey. The detailed assessment processes are described below. Assessment activities will be incorporated into current quality assurance processes to the extent possible.

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

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

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

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

DHSS mailed a survey to all participants receiving adult day care services. The surveys included postage-paid return envelopes. The survey is also available on the DHSS Settings website at: http://health.mo.gov/seniors/hcbs/transitionplan.php. DHSS also hand delivered, through HIV Case Managers, surveys to individuals receiving attendant care services through the AIDS waiver.

On an ongoing basis, questions posed from the participant surveys will be incorporated into annual assessments and reviews.

• Adult Day Care Setting. The participant survey utilized by the Division of Senior and Disability Services (DSDS) was an information gathering tool for initial guidance on participant perspective regarding the compliance of the adult day care setting with the elements of the HCBS Final Rule and will be incorporated into the annual reassessment on an on-going basis. The participant survey report can be found at: http://health.mo.gov/seniors/hcbs/transitionplan.php .

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

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

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

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

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

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

• Right to choose the HCBS provider

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

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

• Discriminatory behavior regarding service delivery

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

42 CFR 441.301(c)(4)(i)/441.710(a)(1)(i)/441.530(a)(1)(i)

42 CFR 441.301(c)(4)(ii)/ 441.710(a)(1)(ii)/441.530(a)(1)(ii)

42 CFR 441.301(c)(4)(iii)/ 441.710(a)(1)(iii)/441.530(a)(1)(iii)

42 CFR 441.301(c)(4)(iv)/ 441.710(a)(1)(iv)/441.530(a)(1)(iv)

42 CFR 441.301(c)(4)(v) 441.710(a)(1)(v)/441.530(a)(1)(v)

• AIDS Waiver. The survey will be released annually January 1 through December 31 with results compiled and a report issued by March 1st. All participants will be mailed a survey, which will include a postage-paid return envelope. The survey will also be available on the DHSS website at: http://health.mo.gov/seniors/hcbs/transitionplan.php .

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

Provider Self-Assessments

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

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

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

• The provider self-assessment is available on the MMAC website at http://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/ for all prospective and currently enrolled providers to utilize at any time.
• The provider self-assessment will be utilized as a pre-enrollment screening tool when MMAC conducts pre-enrollment on-site visits of Adult Day Care providers and AIDS Waiver Attendant Care providers.
• The provider self-assessment will be utilized as a regular tool when MMAC conducts post-payment reviews of Adult Day Care and AIDS Waiver Attendant Care providers. MMAC conducts post-payment reviews of enrolled HCBS providers at least every three (3) years.
• The provider self-assessment will be utilized as a regular tool when MMAC conducts revalidation efforts for Adult Day Care and AIDS Waiver Attendant Care providers. MMAC revalidates providers every five years.
• In addition, MMAC will utilize the provider self-assessment when it is on-site with an Adult Day Care or AIDS Waiver Attendant Care provider for other reasons such as investigations, and
• MMAC will utilize the provider self-assessment as a training tool every six months at Provider Update Training.
• MMAC will compare providers' self-assessments and any MMAC observations with participant responses to DHSS' participant assessments and surveys. Any discrepancies will be followed up by the means necessitated by the level of concern (e.g. an on-site visit with the provider, an audit of the provider's billing and practices, or an investigation.)

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

Settings Assessed:
o Adult Day Care, provided in the Adult Day Care and Aged and Disabled Waivers
o Attendant Care in a Residential Care Facility, provided in the AIDS waiver

General settings are classified into the following categories:

• Yes - Settings presumed fully compliant with HCBS characteristics. The State considers settings where individuals own or lease their homes, or reside with family as fully compliant unless information is provided that would lead the State to believe the setting is institutional in nature. The State would then move the setting to the Heightened Scrutiny review. It is assumed that approximately 13,269 DHSS settings will fall into the "Yes" category.
• Not Yet - Settings may already be compliant, or with changes will comply with HCBS characteristics. The State considers settings where individuals reside in provider-owned or controlled housing of any size, reside in a staff member's home, adult day care program settings, or receive services in a day program setting located in a building that also provides other disability-specific services as not yet compliant but may be with changes. It is anticipated that approximately 79 DHSS provider settings will fall under this category.
• Not Yet - Settings presumed non-HCBS but evidence may be presented to CMS for heightened scrutiny review. The State considers settings located in a building that also provides inpatient institutional treatment, any setting on the grounds of or adjacent to a public institution, or settings that isolate participants from the broader community, such as multiple locations on the same street operated by the same provider (including duplexes and multiplexes) to be not yet compliant, but evidence may be presented to CMS for heightened scrutiny review when the State further evaluates and determines that the setting does meet the qualities for home and community based settings. Approximately 34 settings (physical addresses) through DHSS may fall under this category; and
• No – Settings that do not and cannot meet HCBS characteristics. The state considers settings located in Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) (except Respite), Nursing Facilities/Skilled Nursing Facilities, Hospitals and Institutions for Mental Disease (IMD) to not be compliant.
Heightened Scrutiny Evaluation of HCBS Service Settings and Addresses
MHD worked with DHSS to develop agency processes to identify HCBS Settings and Addresses for Heightened Scrutiny based on the CMS Heightened Scrutiny process:
https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-

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

The State does not intend to submit to CMS for application of Heightened Scrutiny unless the State believes that the setting in fact has the qualities of a home and community based setting, which may include steps that will be taken by the provider as part of an approved transition plan with providers to review specified settings for compliance with the HCBS Settings Rule using the process defined by CMS. The State will engage stakeholders, advocacy organizations, and providers in the review process. The state will further evaluate and continue to work with providers on any setting that may be institutional in nature – by virtue of physical location, or because it is designed specifically for people with disabilities and individuals in the setting are primarily or exclusively people with disabilities and the on-site staff that provide services to them. Per CMS, evidence of how a setting overcomes its presumed institutional qualities should focus on the qualities of the setting and how it is integrated in and supports full access of individuals receiving HCBS into the greater community.

o DHSS gathered information through licensure records to determine which Adult Day Care (ADC) settings were located on the grounds of or adjacent to an institutional setting. DHSS identified seven Adult Day Care Centers located on the grounds of or adjacent to an institutional setting. Upon further clarification and guidance from CMS, DHSS reexamined the Heightened Scrutiny information gathering process. Utilizing the GIS system that DMH used in cooperation with MHD and the state's Office of Administration, DHSS was able to identify ADCs that were unidentified in the previous information gathering process. Beginning October 16, 2014, the State developed a GIS system that layers provider and participant addresses across all agencies. Provider types include HCBS waiver providers such as residential, day services, adult day care, aged and disabled, and employment. It also includes hospitals, nursing homes, and state operated institutions. Service Setting addresses included in this mapping are DHSS sites licensed or certified by the department's Regulation and Licensure Unit, Department of Health and Senior Services Nursing facilities, public institutions, Residential Care Facilities, Assisted Living Facilities, and DMH providers accredited through CARF and deemed certified through the DMH. The GIS system was completed by March 30, 2015.
o DHSS will use GIS to analyze locations of individuals' service settings (co-located and operationally related within 1/8 mile) and settings that provide individuals multiple HCB services in one location and address to identify potential settings that isolate or are institutional in nature.
o DHSS has identified approximately 34 settings that appear to have one or more qualities requiring further review.
• The 34 providers requiring further review are first subject to a Heightened Scrutiny Review by MMAC:
o MMAC will review the 34 providers, ensuring the settings have overcome the presumption of having institutional qualities, yet still fall into one of the "three prongs" for settings presumed not HCBS.
o MMAC will contact those providers to educate them about the Heightened Scrutiny process.
o MMAC will collect and coordinate any participant information provided to them by DHSS.
o MMAC will determine if any of the settings reviewed under any of the three prongs should be elevated to Heightened Scrutiny to CMS, along with an evidentiary package, for review, based upon the following criterion: Did MMAC determine after its review that the provider does not fit any of the three prongs? If the provider still falls under one or more of the three prongs, it will be elevated to CMS for heightened scrutiny review.
• MMAC Heightened Scrutiny Review process will include:
o Determining if the setting is integrated in the community to the extent that the persons without disabilities in the same community would consider it a part of their community and not associate the setting with the provision of services to person with disabilities.
o Determining if individuals participate regularly in typical community life activities outside the setting to the extent the individuals' desire.
o Determining if the setting is co-located with other settings and operationally related to those other settings (owned and operated by the same provider) in such a fashion that individuals' ability to interact with the broader community is limited.
o Determining if the services provided to the individuals, and the activities in which the individuals participate, are engaged with the broader community.
o MMAC will review data to which it has access regarding the billing for and provision of services and compare this to any

information otherwise available regarding the setting as a whole.
o MMAC will conduct a follow up site visit and further assess, in person, the physical location and practices.
o MMAC will receive and coordinate any follow up interviews with participants conducted by DHSS, and any follow up review of participant person-centered care plans conducted by DHSS.
o MMAC will work closely with the provider(s) and their individual transition plan(s) every six months or more frequently if necessary.
• Heightened Scrutiny Review:
• MMAC will submit evidence to CMS regarding the identified providers who "passed" internal scrutiny review and why, and why they are not being referred for heightened scrutiny review
• For those providers who do need to be elevated to CMS for heightened scrutiny review, MMAC will submit types of evidence to CMS to demonstrate that the setting(s) does not isolate individuals receiving HCBS from the broader community of individuals not receiving HCBS, and
• MMAC believes the setting can be brought into full compliance by March 2019; and
• MMAC has demonstrated that persons receiving services are not isolated from the greater community of persons not receiving HCBS
• MMAC has demonstrated that there is strong evidence the setting does not meet the criteria for a setting that has the qualities of an institution.
• MMAC's rationale shall focus on qualities of the setting and how it is integrated in and supports full access of individuals receiving HCBS into the greater community, and strategies the setting has implemented to rectify and fully overcome its former institutional qualities or characteristics that isolate participants. MMAC's rationale shall not focus on the aspects and/or severity of the disabilities of the individuals served in the setting, or why isolating or institutional qualities or characteristics are justified.
• MMAC's rationale may include observations from on-site review(s), licensure requirements or other state regulations, proximity to/scope of interactions with community settings, provider qualifications for HCBS staff, documentation in the person-centered care plan that the individuals' preferences and interests are being met, evidence that that individuals chose their setting, and details of proximity to public transport or other transportation strategies to facilitate integration, and pictures of the site and any other demonstrable evidence. Site visits should focus on the individuals' experiences and the presence or absence of qualities of home and community based settings.
• MMAC will include the full name, location and evidentiary package of each setting to be submitted for CMS review so that public comment information may be added prior to inclusion in the STP and prior to submission to CMS for heightened scrutiny review.
• MMAC will respond accordingly with the provider(s) following CMS response. If the setting does not comply, providers will be afforded the opportunities outlined by CMS, to include implementing necessary modifications by the end of the transition period, furnishing Medicaid services that do not require their provision in an HCB setting, or being recognized as an institution.

• Heightened Scrutiny addresses and evidence packages will be posted for public comment and shared with CMS. Per CMS, evidence of how a setting overcomes its presumed institutional qualities should focus on the qualities of the setting and how it is integrated in and supports full access of individuals receiving HCBS into the greater community.

Initial Settings Assessment Tool Development
MHD required the operating agencies to develop an initial assessment tool to be used by designated state staff for the initial on-site assessments. DHSS was required to begin this process on February 1, 2014 and complete it by December 15, 2014.

o MMAC's Assessment Tool was based on CMS exploratory questions as related to the specific requirements under the regulation. MMAC's initial settings assessment tool is titled "Home and Community Based Setting Survey". The tool will be used during the initial on-site survey of all Adult Day Care Centers and Doorways/Cooper House (AIDS Waiver Attendant Care provider). The MMAC tool may be found at http://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/ .
o MMAC personnel designed and received in-house training regarding the tool and how to utilize it during on-site visits.

Initial On-Site Assessment
MHD required the operating agencies to develop a process and to assess a statistically valid sample of HCBS settings to determine current status of compliance with the HCBS Final rule. Assessments began on December 16, 2014 and were completed by April 1, 2016.

o MMAC completed on-site visits of all 112 Adult Day Care providers and Doorways/Cooper House (AIDS Waiver Attendant Care provider) by April 1, 2016. 100% of these providers were contacted in person (the on-site visit) due to the small number.

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

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

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

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

Informational Letters
MHD required DMH and DHSS to draft informational letters describing the proposed transition, appropriate HCBS Waiver settings, deadlines for compliance, and technical assistance availability. This includes all of the letters that the State will be sharing with stakeholders throughout the process over the next few years. This process began June 23, 2014 and will be completed by April 1, 2017. Information shared with stakeholders includes CMS Guidance, The Code of Federal Regulations, and the Proposed Transition Plan.

Missouri Code of State Regulation (CSR) Filing
The State will file changes to administrative rules as needed to reflect federal regulations on HCBS settings. The rulemaking process is lengthy, entailing a minimum of approximately nine months from the notice of rulemaking to a final rule. The State will begin filing changes to reflect the Home and Community Based Final Rule on March 1, 2015 and will complete the filing by January 1, 2017. The final file date will be dependent upon approval of the Governor's Office.

o As a result of the assessment, DHSS found state standards compliant, partially compliant or non-compliant with the HCBS Rule. Adult Day Care Licensure 19 CSR 30-90, In-Home Service Standards 19 CSR 15-7, Personal Care Rule 13 CSR 70-91, Consumer Directed Services 19 CSR 15-8 will come into compliance upon the adoption and implementation of an overarching HCBS Waiver Administration rule that details the CMS HCBS settings characteristics required for all 1915c waiver settings. The State will add the new chapter to 13 CSR 70 entitled Home and Community Based Services (HCBS) Waivers. This rule implements federal regulatory requirements promulgated by the United States Department of Health and

Human Services, Centers for Medicare and Medicaid Services at 42 CFR 441.301(c)(4) establishing the requirements that must be met for settings in which home and community based services are provided under a 1915(c) HCBS Waiver Program. A Public Comment period of 30 days will be held. Comments are submitted to the agency proposing the rule or rule changes. The agency will prepare a final order of rulemaking that includes summaries of all the comments received, the agency responds to each comment, and any changes made to the proposed rule as result of the comments. The final rule must be filed with the Secretary of State no later than ninety days from the date for filing public comment, or within ninety days after a hearing if a hearing is held on the proposed rulemaking. The new rule change becomes effective thirty days after the final order of rulemaking is published in the Code of State Regulations. Amendments needed to specific manuals are referenced in the remediation column of the crosswalk and language will be added upon CSR implementation.
Direct conflicts in the areas of individual initiative, respect and independence in making life choices, and freedom from coercion and restraint were identified in the Child and Adult Care Food Program manual, which affects participants receiving services through the Adult Day Care Waiver and Aged and Disabled Waiver, adult day care setting. These state guidelines are based directly on federal regulations (7 CFR 226.20) for the program. DHSS will continue to work with partners to address these inconsistencies.

Provider Manuals, Policies, and Procedures Revisions
MHD and DHSS will revise HCBS provider manuals, policies, and procedures to incorporate HCBS final rule requirements. The revisions will clarify expectations of participants' control of their environment and access to the community. Revisions to the provider manuals, policies, and procedures began on January 1, 2015 and will be completed by July 1, 2017.

o DHSS Waiver program manuals and polices were either silent or partially compliant and are in the process of revision to incorporate all components of the HCBS settings rule. The Child and Adult Care Food Manual is in conflict with the HCBS settings rule and DHSS will continue to work with partners to address these inconsistencies.
o Proposed changes for DHSS waivers will be included in each waiver renewal application.

Incorporate Education and HCBS Waiver Compliance Understanding into Provider Enrollment
MHD requires DHSS, and MMAC to educate providers on the HCBS Final rule, and to incorporate education into the Provider Enrollment process. Operating agencies will use resources and tools such as the Missouri Exploratory Questions for Assessment of HCBS Residential Waiver Settings, Missouri – Settings with the Potential Effect of Isolating Individuals from the Broader Community. The requirements of the Home and Community-Based Federal rule will be incorporated into Provider Enrollment Tools and the Provider Agreements. This process began on August 17, 2015 and will continue with all new providers enrolling on an on-going basis.
The State will evaluate through the heightened scrutiny process any new settings for enrollment that have an institutional or isolating quality while presenting deadlines for enrolled providers to come into compliance. Specific processes are outlined below.
o MMAC has posted information regarding the Final Rule and setting requirements on its website for all prospective and newly enrolling providers.
o Newly enrolling HCBS providers will be provided information on HCBS setting requirements as part of their enrollment materials.
o MMAC personnel will educate all HCBS providers about the Final Rule and setting requirements during pre-enrollment on-site visits. Adult Day Care and AIDS Waiver Attendant Care providers will be surveyed during the pre-enrollment on-site visit.
o MMAC will provide information to HCBS providers during Annual Provider Update Meetings held semiannually, Designated Manager Trainings held quarterly, and at other workshops, board meetings, seminars, and conferences.
o MMAC will monitor and verify setting compliance for all Adult Day Care Providers and Doorways/Cooper House at each revalidation. Revalidation occurs at least every five years, and requires an on-site visit to the facility.
o MMAC will monitor and verify setting compliance during on-site audits of Adult Day Care and AIDS Waiver Attendant Care providers. MMAC audits all HCBS providers every three years if not more often.
o MMAC will monitor and verify setting compliance on an ad-hoc, more frequent basis when on-site for other reasons such as an investigation of the provider.
Provider Update Meetings and Trainings
MHD requires MMAC to educate providers on the HCBS Final rule during the Provider Enrollment process. Operating agencies will use resources and tools such as the Missouri Exploratory Questions for Assessment of HCBS Residential Waiver Settings, Missouri – Settings with the Potential Effect of Isolating Individuals from the Broader Community. This education began on June 23, 2014 and will continue ongoing thereafter. The requirements of the Home and Community-Based Federal rule will be incorporated into Provider Enrollment Tools and the Provider Agreements. Specific processes are outlined below.
o MMAC will provide information to HCBS providers during Annual Provider Update Meetings and Provider Designated

Manager Trainings, hosted by MMAC.
o MMAC will provide information to HCBS providers during MHD workshops.
o MMAC will provide information to HCBS providers during HCBS association meetings and conferences.
HCBS Waiver Settings Assessment Findings and Provider Individual Remediation
MMAC posted aggregate initial on-site assessment results on the MMAC website (http://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/). DHSS will provide MMAC with the results of the participant surveys. MMAC will utilize those results by matching any participant surveys that identify the provider, with the provider surveys. MMAC will then conduct a second review to determine consistencies/inconsistencies and will prepare an addendum to the report, which will be posted to the website, as well.

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

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

Providers that become compliant are still subject to a review to verify their compliance. Providers that do not appear to have become compliant, or when there is reason to believe they are not compliant are subject to a review and will also be notified of future consequences (provider sanctions).

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

MMAC Response to Provider Individual Transition Plans
MMAC will receive the individual transition plans. MMAC personnel will track receipt of the plans, conduct an initial review, and continue to review in a semi-annual fashion.
MMAC will provide feedback to providers after the initial reviews and after subsequent reviews. Subsequent reviews will be completed as providers achieve milestones, after they submit updates or changes to their transition plans, and every six months as part of MMAC's semiannual review.

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

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

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

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

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

Assessment Results Report – State Level Remediation
After findings from settings assessments and provider and individual surveys have been presented to CMS, State leadership and stakeholders, the State will work with stakeholders to develop remediation strategies for any necessary systems processes changes. This process will occur between March 2, 2015 and March 17, 2018.

Ongoing Compliance/Monitoring Reviews
MMAC will conduct ongoing reviews of enrolled Adult Day Care and AIDS Waiver Attendant Care providers to establish and monitor levels of compliance. MMAC will incorporate settings requirement information into its pre-enrollment and revalidation site visits of all HCBS providers, and survey the Adult Day Care and AIDS Waiver Attendant Care providers during these visits. MMAC will also provide information about the setting requirements during on-site audits and investigations of HCBS providers.

Ongoing reviews include the following:
• On-site surveys completed during provider revalidation, to occur no less than every five years.
• On-site surveys completed during provider audits, which occur every three years.
• Provider assessments will be used as a training tool during Annual Provider Update Training. This training is held twice a year, and providers attend either the spring session or the fall session
• Provider assessments will be used as a training tool at annual provider association conferences
• MMAC personnel will perform reviews of individual provider transition plans. These reviews will be completed upon receipt, and in a dedicated fashion semiannually. The reviews may be completed more often in cases of provider milestones, or plan changes.
• Ongoing assessment will also occur on an ad hoc basis due to provider investigations, meetings, formal requests for education, and informal communications.
• Reviews may also be conducted when there is reason to believe a provider previously found to be non-compliant has not improved.
• When providers previously found to be non-compliant have improved, spot-checks may still be conducted outside of scheduled audits, investigations, or revalidation efforts, solely for the purpose of checking ongoing compliance levels.

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

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

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

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

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

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

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

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

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

Public Comment Period and Meetings - Amended Transition Plan
This amended Statewide Transition Plan builds on the originally proposed Statewide Transition Plan submitted on March 14, 2015. This plan includes data gathered from the provider and participant self-assessments, information submitted in response to the CMS Letter of Reaction, as well as further details in response to conference calls held with CMS on September 15, 2015 and March 17, 2016 regarding settings and assessment validation. This Amended Transition Plan also reflects guidance that continues to be issued by CMS, including but not limited to the Settings Requirements Compliance Toolkit and the HCBS Training Series Webinars Presented During SOTA Calls (Home and Community-Based Settings, Excluded Settings, and the Heightened Scrutiny Process – November, 2015; and Home and Community-Based Setting Requirements: Systemic and Site-Specific Assessments and Remediation – December, 2015).

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

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

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   The HCBS waiver quality management strategy specified throughout the waiver is used to ensure that the operating agency, the Department of Health and Senior Services (DHSS), is performing the delegated waiver operational and administrative functions in accordance with the waiver requirements during the period that the waiver is in effect. Mo HealthNet Division (MHD) and DHSS meet quarterly to discuss

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

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

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

Where possible, include numerator/denominator.

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

Performance Measure:
PARTICIPANT WAIVER ENROLLMENT: Number and percent of waiver referrals processed within 90 days. Numerator = Number of waiver referrals processed within 90 days. / Denominator = Number of referrals.

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:
WAIVER ENROLLMENT MANAGED AGAINST APPROVED LIMITS: Number and percent of participants assigned a waiver slot not to exceed 100% of approved wavier slots. Numerator = Number of participants assigned a waiver slot not to exceed 100% of approved wavier slots. / Denominator = Number of approved waiver slots.

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:
WAIVER EXPENDITURES MANAGED AGAINST APPROVED LEVELS: Number and percent of reports with annual aggregate cost of waiver services equal to or less than the annual aggregate cost of nursing home care. Numerator = Number of reports with annual aggregate cost of waiver services equal to or less than the annual aggregate cost of nursing home care. / Denominator = Number of reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Financial records (including expenditures)

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:
LEVEL OF CARE EVALUATION: Number and percent of level of care remediation actions completed within 90 days or less by the operating agency. Numerator = Number of level of care remediation actions completed within 90 days or less by the operating agency. / Denominator = Number of LOC remediation actions.

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:

REVIEW OF PARTICIPANT SERVICE PLANS: Number and percent of service plan remediation actions completed within 90 days or less by the operating agency. Numerator = Number of service plan remediation actions completed within 90 days or less by the operating agency. / Denominator = Number of remediation actions.

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**

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:
PRIOR AUTHORIZATION OF WAIVER SERVICES: Number and percent of waiver claims paid that were prior authorized by operating agency. Numerator = Number of waiver claims paid that were prior authorized by operating agency. / Denominator = 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:

Performance Measure:
UTILIZATION MANAGEMENT: Number and percent of participants not receiving waiver services as authorized that were appropriately remediated within 90 days. Numerator = Number of participants not receiving waiver services as authorized that were appropriately remediated within 90 days. / Denominator = Total number of participants not receiving waiver services as authorized.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
MMIS and reports from DSDS.

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 = Confidence Interval = +/-5% and a Confidence Level of 95% or higher.
☐ **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:
RULES, POLICIES, PROCEDURES AND INFORMATION DEVELOPMENT GOVERNING THE WAIVER PROGRAM: Number and percent of policies, procedures and rules reviewed by MHD, applicable to the waiver. Numerator = Number of policies, procedures and rules reviewed by MHD, applicable to the waiver. / Denominator = Total number of policies, procedures and rules released by the operating agency.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
QUALITY ASSURANCE AND QUALITY IMPROVEMENT ACTIVITIES: Number and percent of issues requiring remediation that were properly remediated within 90 days of date of finding. Numerator = Number of issues requiring remediation that were properly remediated within 90 days of date of finding. / Denominator = total number of issues requiring remediation.

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:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Issues which require individual remediation may come to MO HealthNet Division's attention through review of annual reports as well as through day-to-day activities and communications. For example, activities may include review/approval of provider agreements, utilization review and quality review processes, or complaints from MO HealthNet participants by phone or letter relating to waiver

participation/operation. MHD addresses individual problems related to delegated functions as they are discovered by contacting DSDS and advising them of the issue. A follow-up memo or e-mail is sent from MHD to DSDS identifying the problem and, if appropriate, a corrective action resolution. While some issues may need to be addressed immediately, DSDS is required to provide a written response to MHD that specifically addresses the problem identified by MHD. Written documentation is maintained by both MHD and DSDS and, as needed, discussions will be included during quarterly meetings. 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)**	18	64	

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

Initial entry into the IL Waiver is limited to persons with physical disabilities between the ages of 18 and 64 and who live in their own private residence or the home of a family member. Individuals who are receiving IL Waiver services when they turn 65 may choose to continue to participate in the IL Waiver for as long as they maintain the ability and still desire to self-direct their personal care attendant services. Individuals with a cognitive impairment must have the onset of the cognitive impairment on or after age 22. Individuals must be willing and able to self-direct their own care have the capability to hire, train, supervise, direct and fire personal care attendant)

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:

There is no maximum age limit. Individuals who are receiving IL Waiver services when they turn 65 may choose to continue to participate in the IL Waiver.

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	600
Year 2	600
Year 3	600
Year 4	600
Year 5	600

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

It is the states goal to have adequate slots that will prevent the need for a waiting list. However, should a waiting list become necessary, the following protocol shall be used.

Individuals are enrolled based upon the individual meeting the nursing home level of care and criteria specified in this waiver. A high level of unit authorization is representative of individuals who have the greatest need in the State. In the event all slots are filled during a waiver year, priority of available slots will be given to those with the greatest need. Individuals will be enrolled based upon the number of potential units authorized in the task areas listed below, with the largest potential number of units indicating the highest level of need. If individuals have the same level of potential authorized units in the task areas listed below, the date of referral will be used.

Bathing
Bowel/Bladder Routine
Catheter Hygiene
Ostomy Hygiene
Meal Prep/Eating
Turning/Positioning
Assist with Toileting
Bathing
Dressing/Grooming
Assistive with Transfer Device
Mobility/Transfer

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

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

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

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

Select one:

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

Specify percentage:

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

Specify:

Elect to serve all mandatory and optional groups covered under the state plan.

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [ ] **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 spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ( ) **100% of FPL**

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

Specify percentage amount:

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

Specify:

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 an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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

Division of Senior and Disability Services staff, at a minimum, meet the following experience and educational requirements. One or more years of experience as an Adult Protective and Community Worker I, Social Service Worker I, or children's Service Worker I with the Missouri Uniform Classification and Pay System; OR a Bachelor's degree from an accredited college or university in Social Work, Psychology, Sociology, Gerontology, Nursing, Health Care Administration, Education, Counseling, Criminal Justice, or closely related social or behavioral sciences.
Position definition of those performing the initial evaluations are as followed: Adult Protective and Community Worker 1(formerly SSW I): This is entry-level professional social service work in the Department of Health and Senior Services providing protective services and/or coordinating in-home services on behalf of senior and/or disabled adults. Children's Service Worker 1(formerly SSW I): This is entry-level professional social service work in the Children's Division of the Department of Social Services providing protective services on behalf of children and families in instances of abuse, neglect, or exploitation.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

In order to be eligible for entry to the Independent Living Waiver, individuals must meet nursing facility level of care as specified in state regulation at 19 CSR 30-81.030. Points are assigned based on the degree of human assistance needed by the individual (or the frequency of physician's ordered care) in nine categories that explore areas of daily living. The categories are: (1) Monitoring: the amount of medical oversight needed to remain independent. (2) Medications: the ability to administer medicine and difficulty of drug regime. (3) Treatments: physician ordered medical procedure(s) intended to treat a specific medical condition. (4) Restorative: teaching and/or training activities designed to maintain or restore a person to a higher level of functioning. (5) Rehabilitative: physician ordered rehabilitation therapy (speech, occupational, physical) - points are based on frequency of services. (6) Personal Care: bowel or bladder problems or the ability to bathe, shampoo, etc. (7) Dietary: the degree of

specialized diet or the ability to prepare and eat meals. (8) Mobility: the ability to move from place to place. (9) Behavior: any problems associated with orientation, memory recall, and judgment. Scoring Methodology: any combination of points which meets the level of care specified in 19 CSR 30-81.030 qualifies an individual to receive Aged and Disabled Waiver services.
Waiver applicants are initially evaluated for waiver services through the use of a prescreen process. Potential waiver participants will be screened based on the nine level of care categories outlined in B-6-d. Participant information gathered during the prescreen process will be data entered into the web-based system and behind the scenes the level of care will be calculated to determine if the participant meets the criteria for level of care eligibility. Once level of care eligibility is initially determined, a home visit will be scheduled to complete the InterRAI HC ©. The InterRAI HC © will confirm or deny the prescreen level of care determination through the use of behind the scenes decision tree algorithms based on the nine categories outlined in B-6-d. Reevaluations of level of care will utilize the InterRAI HC © with the same algorithms determining continued level of care eligibility utilizing the same nine categories in B-6-d.

The InterRAI HC © has been designed to be a user-friendly, reliable person-centered assessment system that informs and guides comprehensive care and service planning in community-based settings around the world. It focuses on the person s functioning and quality of life by assessing needs, strengths, and preferences. It also facilitates referrals when appropriate. When used on multiple occasions, it provides the basis for an outcome-based assessment of the person s response to care or services. The interRAI HC © can be used to assess persons with chronic needs for care, as well as with post-acute care needs (e.g., after hospitalization or in a hospital at home situation). The interRAI HC © has been designed to be compatible with the suite of interRAI assessment and problem identification tools. Such compatibility advances continuity of care through a seamless assessment system across multiple health care settings, and promotes a person-centered evaluation rather than fragmented site-specific assessments.
The Home Care assessment system, or HC, was developed to provide a common language for assessing the health status and care needs of frail elderly and disabled individuals living in the community. The system was designed to be compatible with the Long Term Care Facility system that was implemented in US nursing homes in 1990-91.
Target Population
The HC was developed for use with adults in home and community-based settings. The instrument is generally used with the frail elderly or persons with disabilities who may or may not be receiving formal health care or supportive services.
The HC was designed to highlight issues related to functioning and quality of life for community-residing individuals. Information is gathered in the following domains:
- Identification Information
- Intake and Initial History
- Cognition
- Communication and Vision
- Mood and Behavior
- Psychosocial Well-Being
- Functional Status
- Continence
- Disease Diagnoses
- Health Condition
- Oral and Nutritional Status
- Skin Condition
- Medications
- Treatment and Procedures
- Responsibility
- Social Supports
- Environmental Assessment
- Discharge Potential and Overall Status
- Discharge
- Assessment Information

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

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

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

An interview is scheduled with a potential waiver participant by a qualified individual as specified in B-6-c. Initial evaluations are conducted face-to-face at the participant's residence and reevaluations are usually conducted face-to-face but may be performed by phone by DHSS staff. Sufficient information is obtained during this interview to complete the LOC evaluation utilizing the HCBS Web Tool as described in the administrative section of the application.
Potential waiver applicants will initially be evaluated for waiver services through the use of a prescreen process. Potential waiver participants will be screened based on the nine level of care categories outlined in B-6-d. Participant information gathered during the prescreen process will be data entered into the HCBS Web Tool system and behind the scenes the level of care will be calculated to determine if the participant meets the criteria for level of care eligibility. Once level of care eligibility is initially determined, an interview will be scheduled to complete the InterRAI HC©. The InterRAI HC will confirm or deny the prescreen level of care determination through the use of □behind the scenes□ decision tree algorithms based on the nine categories outlined in B-6-d. Reevaluations of level of care will utilize the InterRAI HC © with the same algorithms determining continued level of care eligibility utilizing the same nine categories in B-6-d.
The HCBS Web Tool requires LOC reassessments be completed within 365 days of the initial assessment or the last reassessment. Within the HCBS Web Tool the service plan and prior authorization are tied to a current assessment. This design will ensure that services are not reimbursed unless there is a current assessment.
In addition to the DSDS State staff, waiver providers may complete the reassessment InterRAI HC© and provide the information to DSDS staff for entry into the HCBS Web Tool. The actual LOC determination will be made by the State, based on the information in the InterRAI HC©. The DSDS Regional Mangers will be notified 60 days prior to the date the reassessments are due to allow adequate time to schedule a reassessment with the participant to complete the InterRAI©. Regional Managers will be responsible for assigning the reassessments and monitoring this report on a monthly basis to ensure all reassessments are completed within 365 days of the last assessment. In addition DSDS Central Office staff will monitor reassessment reports to ensure they are completed within required timeframes. Should a backlog develop as we move forward the state will address it through remediation based on the specific issue.
The State has taken action to prevent overdue reassessment through system design and change. The State feels timely reassessments have been addressed in a manner that will prevent overdue reassessments as we move forward in the HCBS Web Tool.
Should there be any overdue reassessments due to state staff, the error will be addressed and remediated on an individual basis. Participant services will not be impacted due to any state issue with reassessments. Overdue reassessments as a result of a participant□s unavailability will be handled based on the individual situation of the participant (i.e., hospitalization; nursing home; out of state visiting family, etc.). Services may not resume until the participant receives a reassessment. Waiver services for individuals who refuse a reassessment will be terminated and the participant will receive a fair hearing notice.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

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

  A registered nurse (RN) or an individual with the same qualifications as those established in B-6-c.

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

DSDS Regional staff receive a report of participants, 60 days prior to the date the reassessments are due, to allow adequate time to schedule a reassessment with the participant to complete the InterRAI©. Regional Managers will be responsible for assigning the reassessments and monitoring this report on a monthly basis to ensure all reassessments are completed within 365 days of the last assessment. In addition, DSDS Central Office staff will monitor reassessment reports to ensure they are completed within required timeframes.

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:

Number and percent of initial LOC determination that were completed prior to receipt of a waiver service. Numerator = Number of initial LOC determination that were completed prior to receipt of a waiver service/Denominator= Number of records.

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participant records reviewed with a current assessment completed within the last 365 days. Numerator = Number of participant records reviewed with a current assessment completed within the last 365 days / Denominator=Number of records reviewed

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

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

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

Data Aggregation and Analysis:

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

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

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

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

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Confidence Interval=+/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participant records reviewed with a nursing home LOC determinations completed by qualified staff. Numerator = Number of participant records reviewed with a nursing home LOC determinations completed by qualified staff/ Denominator = Number of records reviewed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant records reviewed with a LOC instruments applied as described in the approved waiver. Numerator = Number of participant records reviewed with a LOC instruments applied as described in the approved waiver/ Denominator = Number of records reviewed

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When an error is discovered during a DSDS case record review or one is identified in a DSDS report, a DSDS supervisor reviews the error, and works with the worker who completed the assessment to appropriately address the error. The worker then documents the action taken. The DSDS supervisor reviews the action taken by the worker to correct the error. General methods of remediation may include: performing a LOC evaluation for those that were not done or re-training staff, discussions during area and regional meetings and/or change in Division policy or procedure.

ii. Remediation Data Aggregation

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

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

Responsible Party*(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:

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

At the initial evaluation qualified individuals as specified in B-6-c explain to the potential waiver participant the services that can be provided through the Independent Living Waiver. Individuals can then make an informed choice between receiving services through a nursing facility or the Home and Community-Based Services, state plan and/or waiver. The form that documents participant choice is the Home and Community Based Services Care Plan and Participant Choice Statement. Individuals are required to document his/her choice via a dated signature on the form, which is also signed and dated by the individual performing the assessment.

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

Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years in the HCBS Web-based system. Copies are maintained in the HCBS web-based system or the DSDS case record until such time the participant is in the HCBS web-based system. Participants are also provided with a signed copy.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
It is the policy of the Department of Health and Senior Services (DHSS) to provide services on a nondiscriminatory basis based on national origin, race, sex, age, disability, color, and religion. As language barriers may interfere with the provision of services to individuals, leading to misunderstandings and impacting program effectiveness, any entity with a contract with DHSS shall comply with all applicable provisions of the Civil Rights Act (45 CFR 80), the Rehabilitation Act of 1973 (45 CFR 84), and all other federal and state laws and regulations relating to nondiscrimination.

Language barriers may interfere with the provision of services to consumers, leading to misunderstandings and impacting program effectiveness. Effective language services are put in place to help prevent these problems. All Department of Health and Senior Services employees and programs must utilize the State of Missouri's contract for providing interpretation and translation services. Guidance and information on the current contract is always available through the Department of Health and Senior Services' Office of Human Resources. The Office of Human Resources informs staff on a yearly basis of this policy/contract via a department-wide email notice. No consumer, applicant, or their representative is required to provide or pay for the services of a translator or interpreter. A family member or friend (must be 18 years of age or older) may be used as an interpreter if this is requested by the consumer and the use of such a person would not compromise the effectiveness of services or violate the consumer's confidentiality and the consumer is advised that a free interpreter is available. Waiver providers' participation agreements (contracts) also require them to meet all obligations/requirements under Title VI of the Civil Rights Act of 1964.

POLICY:
I. PURPOSE:
It is the policy of the Department of Health and Senior Services (DHSS) to provide services on a nondiscriminatory basis based on national origin, race, sex, age, disability, color, and religion.
Language barriers may interfere with the provision of services to clients, leading to misunderstandings and impacting program effectiveness. Effective language services can help prevent these problems.

II. POLICY:
It is the intent of DHSS to:
• establish systems and procedures for the provision of services to any Limited English Proficiency (LEP) individual, particularly those who cannot communicate in spoken or written English;
• improve customer relations between DHSS and the people we serve;
• assure quality translation and interpretation services by obtaining feedback on the performance of translators and interpreters; and
• provide technical support to all DHSS programs.

III. DEFINITIONS
COMMUNICATION: The transfer and understanding of a message from one person to another by means of speaking, writing (including Braille), sign language or illustration.
INTERPRETATION: Spoken transfer and understanding of a message from one language to another.
TRANSLATION: Written transfer and understanding of a message.

LIMITED ENGLISH PROFICIENCY (LEP) INDIVIDUAL: An individual whose primary language is not English and who cannot speak, read, write or understand the English language at the level necessary for effective communication.
METHODS OF ADMINISTRATION: Document signed by DHSS and provided to the U.S. Department of Health and Human Services (USDHHS) specifying methods DHSS will use to implement and assure compliance with Title VI of the Civil Rights Act of 1964 as amended (42 USC 2000d et seq); the Rehabilitation Act of 1973 (29USC 794), hereinafter referred to as Section 504; and the regulations issued there under by USDHHS (45 CFR Parts 80 and 84). It is essential to communicate information in a language other than English when and as required by federal regulations (see Administrative Manual Section 3.2).

IV. COMPONENTS:
A. Responsibilities:
1. All DHSS employees and programs shall utilize the state contract for providing interpretation and translation services. Guidance and information on what contract is currently being used by DHSS will be available through the Office of Human

Resources. The Office of Human Resources will inform staff on a yearly basis of this policy. This contact will be made through a department-wide e-mail notice.
2. All DHSS employees and programs will make reasonable efforts to offer interpretation and translation services when contact has been made with an individual of limited English proficiency. This contact will be recorded by the employee on a LEP Data Form. A copy will be sent or faxed to the DHSS Human Relations Officer.
3. Each DHSS program will determine which materials and forms used by the public will be translated based on an assessment of the population in the services area.
4. Translation materials shall be linguistically and culturally appropriate to the client population.
5. DHSS will strive to provide visual and audio information in the appropriate language to LEP clients. Medically or legally complex materials may be contracted with a vendor for translation.

B. Contracts for Translation or Interpretation:
If vendors are contracted to provide interpretive services and/or perform the translation of materials to other languages, the program will be responsible for associated costs.
C. Contractors:
1. The contractors shall comply with all applicable provisions of the Civil Rights Act (45 CFR 80), the Rehabilitation Act of 1973 (45 CFR 84), and all other federal and state laws and regulations relating to nondiscrimination. The contractors shall assure that no person eligible for services shall on the ground of race, color, religion, national origin (this includes individuals of limited English proficiency), sex, disability, veteran status, or age be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination for any service provided by the contract. The contractors shall, within resources available, ensure minority health issues are addressed in the delivery of services where disparities in health status exist between minority and majority Missourians.
D. Clients of DHSS:
1. No client, applicant or their representative will be required to provide or pay for the services of a translator or interpreter.
2. For LEP clients, DHSS employees will identify and document on client records the primary language/dialect of the client and need for translation or interpretation services.
3. A family member or friend may be used as an interpreter if this is requested by the client and the use of such a person would not compromise the effectiveness of services or violate the client's confidentiality, and the client is advised that a free interpreter is available. The family member or friend must be 18 years of age or older.
E. Responsibility for coordination of this policy is assigned to the DHSS Office of Human Resources.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Case Management**		
Extended State Plan Service	**Personal Care**		
Supports for Participant Direction	**Financial Management Services**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Specialized Medical Equipment and 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:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained; ongoing monitoring of provision of services included in participant's care plan; review of the care plan; identification of abuse, neglect, and/or exploitation; assist in acquisition of necessary assistive technology services and/or devices and advocate for consumers by arranging for services with individuals, businesses and agencies for the best available service within limited resources; and ensuring participants have full access to a variety of services and service providers to meet participants' specific needs, regardless of funding source.Providers of Case Management may not provide direct Personal Care service to the participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Case managers provider shall provide a minimum of 12 hours of case management per year. (For billing purposes, one unit equals up to one year of case management, which includes a minimum of monthly contact with the participant.)

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	Center for Independent Living, Personal Care Agencies, Financial Management Providers, Area Agencies on Aging

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Center for Independent Living, Personal Care Agencies, Financial Management Providers, Area Agencies on Aging
Provider Qualifications

License *(specify):*
This section does not apply.
Certificate *(specify):*
This section does not apply.
Other Standard *(specify):*
Regardless of the provider type, all case management providers must meet the same qualifications, and must comply with the requirements, philosophy and services as specified in Sections 208.900 through 208.930, RSMo and 19 CSR 15-8.

In order to qualify for a written Participation Agreement (contract) with the Department of Social Services, Missouri Medicaid Audit and Compliance Unit (MMAC) the provider shall demonstrate, via the process described in the Entity Responsible For Verification section, that the provider meets the following requirements:

(1) Have a philosophy that promotes the consumer's ability to live independently in the most integrated setting or the maximum community inclusion of persons with physical disabilities. This philosophy includes the following independent living services: advocacy, independent living skills training, peer counseling, and information and referral services.

(2) Programs and procedures are in place for training and orientation of consumers concerning their responsibilities of being an employer, including but not limited to: skills needed to recruit, employ, instruct/train, supervise and maintain services of personal care attendants and preparation and verification of time sheets.

(3) Procedures are established for the maintenance of a list of individuals eligible to be a personal care attendant, if a consumer requests assistance in recruitment. Procedures must ensure each attendant employed by a participant or on the eligible list is registered, screened, and employable pursuant to the Family Care Safety Registry (FCSR), the Employee Disqualification List (EDL) and applicable state laws and regulations.

(4) Procedures are established for educating the participant and the attendant of his or her responsibility to comply with all provisions of section 208.900 to 208.930, RSMo, the regulations promulgated there under in 19 CSR 15-8, and the participation agreement.

(5) Procedures are established for addressing inquiries and problems received from participants and personal care attendants.

(6) Have the capacity and procedures are established to provide fiscal conduit services (Financial Management Services), including but not limited to: performing, directly or by contract, payroll and fringe benefit accounting functions for consumers, including the transmission of the individual payment directly to the personal care attendant on behalf of the consumer and filing claims for MO HealthNet reimbursement.

In order to maintain the written contract with the department, a provider shall comply with the qualification provisions noted above and shall:

(1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial reports and annual audit submitted to the department; and

(2) Demonstrate a positive impact on consumer outcomes regarding the provision of personal care

assistance services as evidenced on accurate quarterly and annual service reports submitted to the department;

(3) Implement a quality assurance and supervision process that ensures program compliance and accuracy of records; and

(4) Comply with all provisions of sections 208.900 to 208.927, and the regulations promulgated hereunder by 19 CSR 15-8.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Social Services, Missouri Medicaid Audit and 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:
Extended State Plan Service

Service Title:
Personal Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Personal care services that are provided when personal care services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from personal care services furnished under the State plan. Additional personal care services provided under the waiver are not limited in amount or frequency. State plan and waiver personal care services are self-directed, with the participant having the authority and responsibility to recruit, hire, train, monitor and fire his/her attendant. Provider qualifications specified in the State Plan apply. Personal care services may be provided outside the participant's home.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Care Attendant

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Personal Care Attendant
Provider Qualifications

License *(specify):*
This section does not apply.
Certificate *(specify):*
This section does not apply.
Other Standard *(specify):*
Personal care attendants must meet the following qualifications:
1. Be at least eighteen (18) years of age;
2. Be able to meet the physical and mental demands required to perform specific tasks required by a particular consumer;
3. Agree to maintain confidentiality;
4. Be emotionally mature and dependable;
5. Be able to handle emergency type situations; and
6. Not be the participant's spouse.

These standards are set forth in Section 208.900 through 208.930, RSMo., and 19 CSR 15-8.

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.

The personal care attendant is an employee of the waiver participant but only for the time period authorized for reimbursement through the waiver program with federal or state funds and is never the employee of the waiver provider, DHSS, or the state of Missouri.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Financial Management Service provider chosen by the participant must verify the attendant meets all provider requirements.
Frequency of Verification:
Prior to employment.

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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services and function that assists participant or their designee to facilitate the employment of staff by the participant, by performing as the participant's agent:

Assist the participant to verify worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable Federal, state and local employment-related taxes and insurance

Ensure the personal care attendant is registered with the family care safety registry as provided in Section 210.900 to 210.937

Financial management services also include information and assistance to the participant or designee in arranging for, directing and managing services. The service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. This service does not duplicate other waiver services, including case management.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Service provider

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:
Agency
Provider Type:
Financial Management Service provider
Provider Qualifications

License *(specify):*
Does not apply
Certificate *(specify):*
Does not apply
Other Standard *(specify):*
Any provider who meets the "Provider Qualifications" specified in the Waiver application, and is capable of performing all requirements of the service definition may enroll as an FMS provider. This includes, but is not limited to, Centers for Independent Living, Personal Care agencies, financial institutions such as banks and credit unions.

Financial Management Service providers must comply with the requirements, philosophy and services as specified in Sections 208.900 through 208.930, RSMo and 19 CSR 15-8.

In order to qualify for a written Participation Agreement (contract) with the Department of Social Services, the FMS provider shall demonstrate, via the process described in the Entity Responsible For Verification section, that the provider meets the following requirements:

(1) Have a philosophy that promotes the consumer's ability to live independently in the most integrated setting or the maximum community inclusion of persons with physical disabilities. This philosophy includes the following independent living services: advocacy, independent living skills training, peer counseling, and information and referral services.

(2) Programs and procedures are in place for training and orientation of consumers concerning their responsibilities of being an employer, including but not limited to: skills needed to recruit, employ, instruct/train, supervise and maintain services of personal care attendants and preparation and verification of time sheets.

(3) Procedures are established for the maintenance of a list of individuals eligible to be a personal

care attendant, if a consumer requests assistance in recruitment. Procedures must ensure each attendant employed by a participant or on the eligible list is registered, screened, and employable pursuant to the Family Care Safety Registry (FCSR), the Employee Disqualification List (EDL) and applicable state laws and regulations.

(4) Procedures are established for educating the participant and the attendant of his or her responsibility to comply with all provisions of section 208.900 to 208.930, RSMo, the regulations promulgated there under in 19 CSR 15-8, and the participation agreement.

(5) Procedures are established for addressing inquiries and problems received from participants and personal care attendants.

(6) Have the capacity and procedures are established to provide fiscal conduit services (financial management services), including but not limited to: performing, directly or by contract, payroll and fringe benefit accounting functions for consumers, including the transmission of the individual payment directly to the personal care attendant on behalf of the consumer and filing claims for MO HealthNet reimbursement.

In order to maintain the written contract with the department, a provider shall comply with the qualification provisions noted above and shall:

(1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial reports and annual audit submitted to the department; and

(2) Demonstrate a positive impact on consumer outcomes regarding the provision of personal care assistance services as evidenced on accurate quarterly and annual service reports submitted to the department;

(3) Implement a quality assurance and supervision process that ensures program compliance and accuracy of records; and

(4) Comply with all provisions of sections 208.900 to 208.927, and the regulations promulgated hereunder by 19 CSR 15-8.

Financial Management Service Providers (FMS) providers must also meet the following requirements:

• Experience completing accounting and payroll activities including processing timesheets and issuing paychecks to employees and making the necessary state, local and federal deductions.
• Develops, implements and maintains an effective payroll system that adheres to all related tax obligations, both payment and reporting.
• Agency/organization must apply for and receive approval from the Internal Revenue Service to be an employer agent in accordance with Section 3504 of the IRS Code and IRS Revenue Procedure 70-6.
• Has an Internal Revenue Service federal employee identification number dedicated to the financial management service?
• Conducts criminal background checks and age verification on personal care attendants.
• Is accessible to assist consumers: has a telephone line with convenient hours, fax and internet access and a customer services complaint reporting system. Includes alternative communication formats.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Social Services, Missouri Medicaid Audit and 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:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home and community, and avoid institutionalization. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All adaptations or improvements shall be provided in accordance with applicable State or local building codes. Adaptations or improvements shall not be provided to living arrangements that are owned or leased by waiver providers. When an institutionalized individual is being transitioned back to the community and waiver environmental accessibility adaptations are deemed necessary and authorized, the adaptations may begin within the 180 consecutive days prior to community transition. Such adaptations cannot be billed until the date the individual leaves the institution and enters the waiver.

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

Adaptations or improvements to the home may be substituted for personal care services when identified as a cost-effective alternative on the participant's care plan. Purchases covered by this category are limited to $5,000 per five year period of time.

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	Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Contractor
Provider Qualifications
License *(specify):*
This section does not apply.
Certificate *(specify):*
This section does not apply.
Other Standard *(specify):*
The FMS provider will assist the participant in obtaining bids for the authorized service to ensure the most efficient use of waiver funds. The FMS provider must ensure that all providers of environment accessibility adaptation are qualified and meets all state and local licensure and or certifications requirements as applicable. The contractor must have applicable business license and meet applicable building codes.
Verification of Provider Qualifications
Entity Responsible for Verification:
The FMS provider.
Frequency of Verification:
Prior to service delivery

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 Equipment and Supplies

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. The agreed to purchase price shall cover the costs of training the waiver participation in the operation and maintenance of equipment. Coverage shall also include the costs of maintenance and upkeep of equipment.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specialized medical equipment or supplies may be substituted for personal care services when identified as a cost-effective alternative on the participant's care plan. With the exception of diapers, purchases are limited to $5,000 in a five year period of time.

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	Medical Equipment and Supply Dealer and/or Retail/Wholesale Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:
Medical Equipment and Supply Dealer and/or Retail/Wholesale Business
Provider Qualifications
License *(specify):*
This section does not apply.
Certificate *(specify):*
This section does not apply.
Other Standard *(specify):*
The FMS provider will assist the participant in obtaining bids for the authorized service to ensure the most efficient use of waiver funds. The FMS provider must ensure that all providers of medical equipment and supplies are qualified and meets all state and local licensure and or certifications requirements as applicable. Enrolled with Medicaid as a state plan Durable Medical Equipment Provider or be registered and in good standing with Missouri Secretary of State's office.
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS provider
Frequency of Verification:
Prior to service delivery

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

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

Waiver providers are required to perform criminal/background investigations on staff that provide direct care to Waiver eligible individuals prior to employment.

Provider agencies request these investigations through the Missouri Department of Health and Senior Services, Division of Regulation and Licensure, Family Care Safety Registry. The Registry helps to protect Waiver eligible individuals by compiling and providing access to background information. 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

MMAC is responsible for monitoring the waiver 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.

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):

Waiver providers are required to perform an abuse registry screening on staff that provide direct care to Waiver eligible individuals prior to employment.

All personal care attendants must undergo an abuse registry screening (Employee Disqualification List [EDL]) prior to employment with a waiver participant. Any potential attendant listed on the EDL is deemed ineligible for employment. The EDL is maintained by the Department of Health and Senior Services. Screenings against the EDL can be handled through the Family Care Safety Registry (explained in C-2-a).

MMAC is responsible for monitoring the waiver providers to assure that EDL screenings are conducted as required by statute and regulation. This monitoring will be conducted during regular monitoring visits, requested technical assistance visits and complaint investigations.

Appendix C: Participant Services

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

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

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

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

There are no timeframes for provider enrollment. Open enrollment is ongoing throughout the year. Providers may contact the MMAC 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 MMAC, Provider Enrollment Unit.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and percent of new providers who meet initial waiver provider requirements. Numerator = Number of new providers who meet initial waiver provider requirements. / Denominator = Total number of Adult Day Care providers.

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

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

☑ **State Medicaid 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:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled waiver providers who continue to meet waiver provider requirements following initial enrollment, according to State policy and timelines. Numerator = Number of enrolled waiver providers who continue to meet waiver provider requirements following initial enrollment, according to State policy and timelines. / Denominator = Total number of waiver providers.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
Number and percent of quarterly reports from providers that indicate employment taxes were paid. Numerator = Number of quarterly reports from providers that indicate employment taxes were paid. / Denominator = number of quarterly reports.

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

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 provider annual audits submitted timely. Numerator = Number of provider annual audits submitted timely. / Denominator = Total number of annual audits due.

Data Source (Select one):
Financial audits
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:

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 consumers were met. Numerator = Number of providers submitting documentation that training requirements for consumers were met. Denominator = The number of providers.

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

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

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**

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Missouri Medicaid Audit and Compliance (MMAC) notifies the provider in writing immediately when problems are discovered. MMAC forwards a copy of the notification letter to 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. A corrective action plan is received from the provider and put in the file. At the next post payment review the analyst checks to see if the corrections were implemented.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.
- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.
- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.
- [ ] **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Home and Community Based Services Care Plan and Participant Choice Statement (DA-3) and the Prior Authorization Screen from the HCBS Web Tool, in conjunction with the InterRAI HC.

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:

- ☑ **Other**

  Specify the individuals and their qualifications:

  Division of Senior and Disability Services staff shall, at a minimum, meet the following experience and educational requirements. One or more years of experience as an Adult Protective and Community Worker I, Social Service Worker I, or Children's Service Worker I with the Missouri Uniform Classification and Pay System. OR A Bachelor's degree from an accredited college or university in Social Work, Psychology, Sociology, Gerontology, Nursing, Health Care Administration, Education, Counseling, Criminal Justice, or a closely related social or behavioral science.

  Position definitions of those performing the initial evaluations are as followed:
  Adult Protective and Community Worker 1(formerly SSW I): This is entry-level professional social service work in the Department of Health and Senior Services providing protective services and/or coordinating in-home services on behalf of senior and/or disabled adults.

  Children's Service Worker 1(formerly SSW I): This is entry-level professional social service work in the Children's Division of the Department of Social Services providing protective services on behalf of children and families in instances of abuse, neglect, or exploitation.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) The initial service plan is developed by DSDS staff. Service plans are reviewed by DSDS no less than annually. Participants, providers, family members, physicians, etc. may request changes to the service plan. Any change to the service plan is subject to the review and approval of DSDS staff. The care plan is developed at the time of the assessment or reassessment with the participant and anyone they choose. The individual performing the assessment contacts the participant to schedule an appointment convenient for the participant. This process allows

the participant to have anyone they choose there during the care planning process. The care plan is updated when DSDS staff is contacted by the provider or participant that there has been a change in the participant's circumstances or needs.
(b) The InterRAI HC is a comprehensive internationally recognized home care assessment that supports service plan development including the needs, preferences, goals, risks, and health status of the participant.
(c) The services available through the Independent Living Waiver are described/explained to the participant and other attendees during the assessment and service plan development process. The actual provider is selected through the participant□s choice and provider availability.
(d) During the comprehensive assessment, the goals, needs, and preferences of the participant are identified and addressed in the service plan. The InterRAI HC is comprehensive assessment tool which not only determines the Level of Care of the individual, but looks at the participant risks and strengths as related to community living. Although necessary at times, independent contact with other individuals shall not compromise the rights and preferences of the participants. If additional information gathered during the design of a service plan creates a discrepancy with the expressed wishes of a participant, additional discussions and documentation shall take place. Additional medical issues may be identified that require the participants to be informed of any potential barriers, which will prompt additional discussion about how to address these issues. Appropriate referrals are made to other resources necessary to assist the participant in achieving optimal independence. When the participant receives services from other agencies, coordination of services to assure continuity of care without duplication of services may be necessary. DSDS staff and the waiver provider will assist participants in the implementation of services authorized or other areas identified within the service plan.
(e) DSDS staff, the waiver provider staff, and the participant coordinate the implementation of the service plan, including non-waiver services.
(f) DSDS staff, the participant, and the FMS provider are responsible for implementation and compliance with the service plan. The right of self-determination shall necessitate the individual□s participation and approval of the service plan.
(g) Service plans are reviewed by qualified individuals as warranted, but no less than annually.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

During the assessment, evaluation and care planning process risks are assessed such as: identifying support systems or lack thereof, and confusion factors. Once the assessment/evaluation process identifies possible risk factors and needs, a determination is made as to whether or not these factors will be alleviated through service planning, or if referrals should be made to and coordinated with other community supports. These needs are noted on the HCBS Care Plan and Participant Choice Statement (DA-3) in order to document what actions are taken to mitigate any risk problems. During the assessment process, participants are made aware of the need to have in place back-up plans to address contingencies such as emergencies, natural or man-made disasters, failure of the waiver provider staff to show up as scheduled, etc. Types of back-up arrangements that could be utilized are discussed and identified with the participant and documented on the assessment tool, which is a companion document to other service planning documents. These arrangements could include but are not limited to: awareness of emergency contact number for the waiver provider, contact names/phone numbers of individuals that could be reached 24/7, listing of family members or others that are willing/ready to act as back-up aides or assist participant in various ways, arrangements with someone to check on participants on an at least daily basis, and registration with utility companies to ensure utilities are returned to service quickly, if necessary. Waiver participants are also advised of the "Ready in 3" portion of the Department's website (http://health.mo.gov/emergencies/ert/index.php). Endorsed by the American Red Cross and the State Emergency Management Agency, the "Ready in 3" information focuses on 3 steps that participants can take to prepare for many kinds of emergencies: 1) create a plan, 2) prepare a kit, and 3) Listen for information. Additionally all qualified providers are subject to universal reporting of abuse, neglect, and exploitation. Missouri statute also includes specific language in certain sections that mandate various entities to report abuse, neglect, and exploitation. When abuse, neglect, and exploitation indicators are noted during assessment/evaluation process, a report is to be made to the DHSS Central Registry Unit as outlined in G-1-b. Response to the report is further defined in G-1-d. Strategies to mitigate identified risk of abuse, neglect,

and exploitation to the participant are discussed with the participant by DSDS staff and developed within a protective service plan as outlined in G-1-e.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A list of eligible providers is reviewed with the participant during the initial service planning process. Participants may choose the provider they want from this list. Participants can also access a MO HealthNet Provider Search function on the DSS/MHD website (www.dss.mo.gov). Participant choice is documented on the care plan by the participants signature. A copy of the statement documenting participant choice is maintained in the HCBS Web Tool.

A list of all qualified providers is available to the participant annually at reassessment, or anytime they request a provider change. New providers are added to the provider list on a continuous and ongoing basis.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

DSDS staff develop the initial service plan and review the service plan no less than annually. A change to the service plan may be requested by anyone including the participant when there is a change in the participants needs however all service plan changes are subject to the review and approval of DSDS staff and include discussion with the participant.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

Waiver provider and participant

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

(a) DSDS staff are responsible for monitoring and assuring the implementation of the service plan.
(b) DSDS contact new waiver participants within 10 days of the prior authorization date to ensure that the services have begun and meet the participant's needs. The waiver provider is required to ensure prompt initiation of authorized services, not to exceed seven (7) days of the prior authorization date. When services are not initiated within the required time, the provider reports this information to DSDS. In addition to the 10 day follow-up by DSDS the waiver provider is required to monitor, at least monthly, the provision of services to ensure services are being delivered in accordance with the care plan. DSDS staff are to be contacted immediately regarding any critical issues identified during the monitoring. Service plan changes could be initiated as a result of these evaluations of the participant's status and service plan. Participants are advised of their right of provider choice, if service provision is an issue with the participant.
(c) At least annually, direct contact is made with the participant. Information discussed and provided to participants annually during the assessment and reassessment process includes the following statement: "I agree to notify DSDS staff at _____ (Regional Evaluation Team) any time there is a change in my circumstances that may affect the person centered care plan, when I am not satisfied with the services or treatment I received from the provider, I want to change providers, or when I have any unresolved issues with the aide." Once this is discussed with the participants and or their guardian, they acknowledge they understand by initialing this statement and signing the form.
No less than annually DSDS conducts case record reviews on a statistically valid sample of participants to identify any issues related to the waiver assurances and sub-assurances including level of care, plan of care (including non-waiver referrals and supports), health and welfare, and provider choice.
No less than annually DSDS will provide the Medicaid agency with reports related to the performance measures as specified in the quality section of Appendix D.
The effectiveness of the back-up plan is reviewed with the participant as needed but no less than annually.

b. **Monitoring Safeguards.** *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of participant service plans that address the participants' assessed need. Numerator = Number of participant service plans that address the participants' assessed need / Denominator = Number of service plans reviewed

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant service plans that identify participant goals.
Numerator = Number of participant service plans that identify participant goals /
Denominator = Number of service plans reviewed

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant service plans that document identified risks were addressed/discussed with the participant. Numerator = Number of participant service plans that document identified risks were addressed/discussed with the participant / Denominator = Number of service plans reviewed

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

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(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 = Confidence Interval=+/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participant service plans developed by qualified staff specified in the waiver. Numerator = Number and percent of participant service plans developed by qualified staff / Denominator = Number of service plans reviewed

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service plans that document the participant was informed that anyone they choose can participate in their service plan development. Numerator = Number of service plans that document the participant was informed that anyone they choose can participate in their service plan development/ Denominator = Number of service plans reviewed

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

participant service plans that were reviewed or revised within 365 days of the most recent service plan/ Denominator = Number of service plans reviewed

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

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

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 participant service plans that were updated when the participants' needs changed. Numerator = Number of participant service plans that were updated when the participants' needs changed. Denominator = Number of service plans reviewed with an identified change in need

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participant's service plans reviewed where services were delivered in accordance with the service plan. Numerator = Number of participants service plans reviewed where services were delivered in accordance with the service plan/ Denominator = Number of service plans reviewed

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 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:

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

Performance Measures

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When an error is discovered during a DSDS case record review or one is identified in a DSDS report, a DSDS supervisor reviews the error, and works with the appropriate worker to address the error. The worker then documents the action taken. The DSDS supervisor reviews the action taken by worker to correct the error. General methods of remediation may include: service plan revisions, re- training staff, discussions during area and regional meetings and/or change in Division policy or procedure.

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**

Responsible Party*(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:

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)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

If it is determined during the assessment/evaluation process that a need exists for personal care attendant services, participants are advised of the consumer-directed model and the agency model. If the participant chooses the self-direction model and personal care services are necessary over and above the state plan maximum limit, s/he can receive extended personal care services through the Independent Living Waiver. Independent Living Waiver services that participants may self-direct are limited to personal care attendant services.

During this process, the individual is provided a description of responsibilities under the self-directed model, which includes: recruitment, hiring, training, and supervision of the attendant; willingness to employ attendants who are registered, screened, and employable pursuant to the Family Care Safety Registry, Employee Disqualification List, and applicable state laws and regulations; preparation of biweekly time sheets; submission of time sheets to the FMS provider; ensuring that units denoted on time sheets are within the authorized amount; prompt notification to DSDS or the FMS provider of changes in the participant's circumstances affecting the service plan and/or changes in the participant's information (address, phone number, etc.); and notification to DSDS staff or the FMS provider regarding any problems resulting from the quality of services rendered by the attendant.

When a participant chooses the self-direction model and functions as the employer, the FMS provider selected by the participant conducts fiscal conduit services, including, but not limited to, transmitting payment to attendants, applicable payroll taxes, etc.

FMS providers are required to support the waiver participant by providing training and orientation of the participants in the skills necessary to recruit, employ, instruct, supervise and maintain the services of attendants. If a participant has concerns about the training provided or feels that adequate support is not provided by the FMS provider, the participant is directed to contact DSDS. DSDS will assist the waiver participant and FMS provider in resolving the issue or will assist the waiver participant in selecting another FMS provider.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [ ] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- (●) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ( ) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Participants learn about participant directed options during the assessment/evaluation/service plan development conducted by DSDS staff, when needs are identified and ways of supporting the needs are discussed. The participant directed possibilities must be discussed with interested participants at this time. These discussions will include an explanation of the benefits of participant direction (hiring an attendant of the participant's choice, flexibility in scheduling the authorized services, etc.), responsibilities outlined in Appendix E-1 a. and the potential liabilities that may be involved in order to ensure the participant can make an informed choice on the services they wish to utilize to meet his/her agreed upon needs.

Information on participant direction opportunities is also provided by the FMS provider. In addition, FMS providers are required to provide detailed training and orientation to participants regarding their responsibilities related to consumer directed services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ( ) **The State does not provide for the direction of waiver services by a representative.**
- (●) **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- [ ] **Waiver services may be directed by a legal representative of the participant.**
- [x] **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver participants are allowed to elect a designee of their choice to direct their care, i.e., make decisions on hiring and firing attendants, make recommendations on the scheduling of the attendant, complete and sign attendant timesheets on behalf of the participant. The designee may not be the paid personal care attendant. The designee must be capable of fulfilling the requirements of the program on behalf of and as directed by the participant. A monthly contact by the FMS provider is intended to monitor all aspects of program participation, including actions taken by the designee, to ensure they are in the best interest of the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Care	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:
Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Enrolled Financial Management Service (FMS) providers will provide services through the Fiscal/Employer Agent. Enrolled provider requirements will be published and placed on the MHD Website and/or in the

MHD ILW provider manual. Organizations interested in providing FMS services are required to submit a signed Provider Addendum to the Missouri Medicaid Audit and Compliance (MMAC) prior to enrollment to provide the service. The addendum identifies the waiver program under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements.

The FMS provider addendum and accompanying documentation are reviewed by the MMAC and all assurances are satisfied prior to assigning the provider specialty by the MMAC. Once approved by MMAC the FMS provider will be notified that they may begin to provide FMS services.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers will be reimbursed a prior authorized per member per month through a claim submitted by the provider to the Medicaid Management Information System (MMIS).

The reimbursement rate for FMS provided through the ILW is based on cost analysis associated with the provision of this service. In addition, industry standards and information from other states for reimbursement of FMS was considered. Missouri also consulted with ILW providers regarding costs associated with FMS.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [ ] **Maintain a separate account for each participant's participant-directed budget**
- [ ] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [ ] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Missouri Medicaid Audit and Compliance (MMAC) verifies the FMS provider meets waiver standards and state requirements to provide FMS services prior to enrollment. These standards are also verified through a review process. FMS providers will be required to submit to MMAC an annual report that is completed by a licensed independent practitioner (Certified public accountant licensed in the state of Missouri). This annual report should include all standard reports according to generally accepted accounting principles, which shall include but not be limited to Balance sheet, Statement of Revenue, Expenditures and Changes in Fund Balance (detailed i.e. travel, supplies, rent, etc), Budgetary Comparison Schedule and any relevant ownership and disclosure information to include shares distributed to stakeholders and the stakeholder's interest in company. For the FMS providers, this report must also include a review of all FMS payroll functions including state and federal tax calculations, reporting and payments. This report will be reviewed by MMAC staff. MMAC will conduct a biennial review and verification of the time sheet and billing process as well as the aides' background screening. A system of data collection and remediation will be implemented to address individual provider issues and identify opportunities for system changes.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Financial Management Services	☑
Environmental Accessibility Adaptations	☐
Specialized Medical Equipment and Supplies	☐
Personal Care	☐
Case Management	☑

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

When a waiver participant voluntarily chooses to no longer self-direct his/her personal care attendant services through the waiver, participation in this waiver as a whole will be terminated. DSDS field staff will advise the participant of the availability of agency-model personal care services, Aged and Disabled Waiver services (for individuals age 63 and above), Adult Day Care Waiver, and/or other community resources. If the participant chooses to utilize the agency-model services (state plan or waiver), DSDS staff will provide a listing of eligible providers from which the participant selects their provider of choice. DSDS staff will then coordinate with the Waiver provider and the agency-model provider to ensure a smooth transition from Independent Living participant-directed waiver services to the state plan agency-model without loss of services during the transition period to assure participant health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

When a waiver participant is deemed ineligible to continue to self-direct his/her personal care attendant services through the waiver, participation in this waiver as a whole will be terminated.

Involuntary termination of consumer-directed services could be precipitated by a participant's inability to continue directing his/her own care, persistent noncompliance with the service plan, intentional fraud of the program, abuse of the attendant or provider staff, and/or risks to health and safety cannot be mitigated. Ability to self-direct care will be established via the same criteria utilized to determine eligibility for entrance to the waiver.

In all cases, the FMS provider will counsel the participant to assist in understanding the issues, let the participant know what corrective action is needed, and determining whether or not the participant can benefit from additional training. If the participant refuses to cooperate or the issue cannot be resolved, the FMS provider would notify DSDS so that necessary services may be offered to the individual through agency-model services (state plan or waiver) or other community resources.

DSDS staff will then coordinate with the FMS provider and the state plan agency-model provider to ensure a smooth transition from participant-directed services to the state plan agency-model without loss of services during the transition period to assure participant health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	600	
Year 2	600	
Year 3	600	
Year 4	600	
Year 5	600	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**

- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [ ] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

During the assessment/service planning process, potential waiver participants are advised of their right to appeal and participate in a fair hearing when they are adversely impacted, i.e., denied services, feel their freedom of choice in selecting HCBS vs. institutional services or provider(s) is denied, he/she is in disagreement with the level of care determination or service planning results, services are reduced, suspended, or terminated. This information/process is discussed with the participant by DSDS staff or its designee. This information is also provided in writing to the participant when services are recommended; the participant will be requested to sign an acknowledgement that the appeal/fair hearing process has been explained to him/her.

In the event of an adverse action as described above, the waiver participant is advised verbally of the proposed action. The participant also receives a written adverse action notice that specifies the proposed adverse action, his/her right to appeal the action and to request a fair hearing on the action, and confirmation that the request for a hearing must be made within 90 days of receipt of the adverse action notice. The written adverse action notice also advises the participant that if a hearing is requested within 10 calendar days of receipt of the adverse action notice, services will continue as authorized at that time pending the hearing decision.

Participants can appeal the adverse action and request a hearing in writing, or may verbally contact DSDS or its designee, who will assist in the completion of the request for hearing form and submit it to the Department of Social Services, Division of Legal Services for the participant.

Copies of adverse action notices and requests for hearing are maintained in the HCBS Web Tool.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical incidents include abuse (physical, sexual, or emotional; exploitation; and misappropriation of funds/property) and neglect (self, or by others). Missouri statutes include a universal mandated reporting, stating that any person having reasonable cause to suspect that an eligible adult is experiencing abuse or neglect and 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. (660.255, RSMo) Missouri statutes also include specific language in certain sections that mandate various entities to report possible abuse and/or neglect or cause a report of possible abuse and/or neglect to be made to DHSS. The entities that are mandated to report are: 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; funeral director; home health agency or home health agency employee; hospital and clinic personnel engaged in examination, care, or treatment of persons; in-home services owner, provider, 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 covers IL Waiver providers); personal care attendant; or social worker. When any of these entities has reasonable cause to believe that a participant has been abused or neglected they are to immediately 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 within a reasonable time after the act of abuse or neglect are guilty of a Class A misdemeanor (198.070 and 660.300, RSMo). The methods of reporting include calling DHSS staff or the Central Registry Unit 800# (this number is promoted on DHSS public information, brochure, posters, and website), written correspondence with DHSS or through the 'Ask Us' function on DHSS' website. All reports are logged in the Mo CaseCompass system, regardless of the method utilized to report, in order to track all reports.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DSDS and waiver providers provide participants with information (verbally and in written format) about reporting policy and procedures for incidents at the time of enrollment, annually, and any time the waiver participant perceives that his/her rights and/or responsibilities have been violated. DHSS staff, DSDS, and its designee, etc., instruct the waiver participant, legally responsible parties, and any informal caregivers about the types of critical incidents and all the methods/options for reporting incidents of abuse, neglect, or exploitation to DHSS. The 'Home and Community Based Services Care Plan and Participant Choice Statement' document that participants sign includes the sentence, "I understand I can call the toll-free hotline at 1-800-392-0210 to report abuse, neglect, or exploitation." This document is gone over thoroughly with waiver participants at time of entry into the waiver and at least annually thereafter.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Department of Health and Senior Services (DHSS) is the mandated adult protective services agency in Missouri. Statute 660.260, RSMo defines the investigatory authority of DHSS as limited to eligible adults with a protective service need. DHSS/DSDS staff shall investigate and offer protective services to all eligible adults when deemed appropriate. This shall include: 1) adults age 60 years or older who are unable to protect their own interests or adequately perform or obtain services which are necessary to meet their essential human needs, and 2) adults with disabilities between the ages of 18 and 59 who are unable to protect their own interests or adequately perform or obtain services which are necessary to meet their essential human needs. Reports may be received that would not fall within the scope of DHSS' authority but may be appropriately referred to another agency for assistance. All reports are registered by DSDS Home and Community Services or Central Registry Unit (CRU) staff into the states reporting data base system, Mo CaseCompass. The following is applicable to waiver participants receiving services in their own home: Preliminary classification of reports is based on information received from the reporter at the point of intake. Classification is based on the level of harm or risk to the reported 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, but must be initiated within set timeframes. DHSS staff are responsible for the investigative process. Mo CaseCompass develops a baseline investigation plan which includes standard set of Activities/Tasks for an investigation. The investigator can add additional activities/task as needed. The investigative plan is completed inside the Mo CaseCompass system providing notifications and alerts to the investigator of required policy tasks and completion of investigation. Depending on the report, the investigation plan may include a combination of Activities/Tasks to address: 1) Review of the report and conducting background checks of the subjects of the report. 2) Development of an investigative plan, outlining the actions to be taken in accordance with the reported information. The investigative plan will include the assessed need to involve medical professionals; the order of the interviews to be conducted, i.e., reporter, reported adult, witnesses and the alleged perpetrator; determination of which records or documents need to be obtained to (dis)prove the allegations in the report; evidence suggested in the report to be immediately obtainable which will assist in (dis)proving the allegations and determination of which agency or entity (if any) that needs to be contacted to co-investigate or provide support. 3) A thorough investigation is conducted obtaining all information necessary to determine whether the alleged abuse, neglect or exploitation actually occurred (or is occurring). The information is gathered and memorialized through documentation to properly preserve the evidence. 4) Evaluation, analysis, organizing and reviewing the information to determine if legal intervention or protective services is warranted. This shall include further follow-up and resolution when there are discrepancies or inconsistencies, evaluating the risk of harm or injury to the reported adult and assessing the capacity of the reported adult and providing necessary interventions. 5) Completion of a summary and determining the investigative conclusion according to the information obtained during the investigation. This will include recording all contacts and activities related to the investigation in the case record. 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. 6) Policy requires that investigations are conducted and completed and findings/results entered into the Mo CaseCompass system within a ninety (90) day period. Class I reports are to be forwarded to investigative staff immediately; 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 with the 24 hours following receipt of a report to ensure the safety and well being of a reported adult. The 24-hour period will begin at the time the information was 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. 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, 660.263, 660.320 and 660.321, 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.

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 100% of all third party perpetrator reports and 100% of all Class 1 reports regarding imminent harm as well as periodic reviews of all other reports. Supervisor reviews are triggered based on criteria in the Mo CaseCompass system. 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. 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 possibly go on interviews with the investigator. This oversight is also conducted on an ongoing basis. The Mo CaseCompass system is utilized to collect information on alleged reports 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 past similar allegations were handled. DSDS is mandated to put in place 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. Waiver participants that have been placed under 'protective service' status are identified along with the level of protective service needed. These levels are: Indicative of a minimal but consistent need for protective intervention with the intent to reduce injury/harm by increasing support system and regular contacts to be made as needed to the support system and a minimum of one home visit every six months, or- Indicative of a moderate need for protective intervention with contacts to occur on a regular basis averaging at least twice per month and a minimum of one home visit every six months, or- Indicative of intense need for protective intervention with contacts to occur with and/or on the behalf of the participant weekly and a home visit monthly.

Participant information is collected and compiled in the state reporting data base, Mo CaseCompass. The methods of reporting include calling DSDS staff or the Central Registry Unit 800# (this number is promoted on DHSS public information, brochure, posters and website), written correspondence with DHSS or through the 'Ask Us' function on DHSS' website. All reports are registered in the Mo CaseCompass system, regardless of the method utilized to report, in order to track all reports. Information gathered on abuse, neglect, and exploitation are used to prevent reoccurrence through education and changes in policy and procedures including but not limited to staff and provider training and public awareness. DSDS provides summary reports to the State 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:

All waiver services are performed in the participant's home. Use of restraints or seclusion is not addressed by the MHD or DHSS in this waiver program. Suspected inappropriate use of restraints or seclusion would be reported to DHSS through the same methods by which abuse and neglect is reported and investigated. Waiver providers and DHSS workers would recognize the use of restraints or seclusion and are mandated to report such. The suspected inappropriate use of restraints or seclusion would be detected through assessment, observation and communication.

○ **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:

  All waiver services are performed in the participant's home. Use of restrictive interventions is not addressed by the MHD or DHSS in this waiver program. Suspected inappropriate use of restrictive interventions would be reported to DHSS through the same methods by which abuse and neglect is reported and investigated. Waiver providers and DHSS workers would recognize the use of restrictive interventions and are mandated to report such. The suspected inappropriate use of restrictive interventions would be detected through assessment, observation, and communication.

- ( ) **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 or accompanying the participant in community activities. These homes are owned/rented by the participant/caretaker. Provider staff make monthly phone contact with the participant and/or responsible party. Additionally, an annual reassessment is conducted by state staff. Vendor staff are mandated reporters of abuse and neglect, which includes unauthorized restraint and

seclusion. Possible incidents of seclusion will be documented and reported to the Central Registry Unit (CRU) at DHSS if abuse, neglect or exploitation is suspected.

○ **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.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. **Provider Administration of Medications.** *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants' hotline investigations that were initiated within required time frames or received supervisory approval.
Numerator = Number and percent of waiver participants' hotline investigations that were initiated within required time frames or received supervisory approval /
Denominator = Number of hotlines reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated
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 = Confidence Interval =+/-5% and a confidence level of 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant records reviewed with documentation the participant/legal guardian received information about how to report abuse, neglect, and exploitation. Numerator = Number of participant records reviewed with documentation the participant received information about how to report abuse, neglect, and exploitation. Denominator = Number of records reviewed

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant records reviewed where the participant and/or family or legal guardian was provided information on who to contact regarding complaints. Numerator = Number and percent of participant records reviewed where the participant and/or family or legal guardian was provided information on who to contact regarding complaints/ Denominator = Number of records reviewed

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

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

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 participant records reviewed that document the participant has a back-up plan that is subject to the participants' needs and preferences. Numerator = Number and percent of participant records reviewed that document the participant has a back-up plan that is subject to the participants' needs and preferences/ Denominator = Number of records reviewed

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

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.

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.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When an error is discovered during a DSDS case record review or one is identified in a DSDS report, a DSDS supervisor reviews the error, and works with the appropriate worker to address the error. The worker then documents the action taken. The DSDS supervisor reviews the action taken by worker to correct the error. General methods of remediation may include: service plan revisions, re- training staff, discussions during area and regional meetings and/or change in Division policy or procedure. Problems related to timely investigation of hotlines are addressed through staffing and or staff training and or policy and or procedures as deemed appropriate.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

No less than annually MHD Program Operation staff and DSDS Program Oversight staff meet to discuss the Quality Improvement Strategy described throughout the Adult Day Care, Aged and Disabled, and the Independent Living Waivers.
At this time, DSDS Program Oversight staff and MHD Program Operations staff jointly review the performance measures and analyze corresponding reports generated by both agencies. MHD and DSDS review the outcome of the reports to ensure they are meeting the assurances specified throughout the application and what, if any, action may be necessary for remediation and or system improvement.
Systemic errors and trends are identified by MHD and DSDS based on the reports for each performance measure using the number and percent of compliance.
Recommendations for system change may come from either agency however MHD will approve any changes to the Quality Improvement Strategy specified in the waiver application. Any changes in the Quality Improvement Strategy in the waiver application are implemented and monitored, as appropriate. Any changes will be included on the next 372 report.
System improvement activities related to participant health, welfare, and safety are the first priority for MHD and DSDS staff. Additional priorities are established based on the number and percent of compliance specified in the waiver reports for the Quality Improvement Strategy in the waiver.
Although individual problems are remediated upon discovery, performance measures that are significantly lower than 100% may need to be addressed as a systemic issue. Implementation of system improvement will be a joint effort between DSDS and MHD. System change related to delegated activities will be the responsibility of DSDS and those activities that are not delegated will be the responsibility of MHD. Follow-up discussions related to system improvement activities may be discussed at quarterly meetings but will be discussed no less than annually.
Systemic issues may require follow-up reports, policy and or procedure changes, as well as staff and/or provider training

MHD and DSDS will analyze the effectiveness of system improvement activities through the Quality Improvement Strategy reports and or additional reports that may be recommended by DSDS and or MHD when significant areas of concern are identified.
All reports are stratified by 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 DSDS through increased reporting or monitoring as deemed necessary and appropriate. Results of the system improvement report will be available on the DSDS web site.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Home and Community Based Services Waiver Quality Management Strategy specified in the Adult Day Care Waiver (1021), Aged and Disabled Waiver (0026), and Independent Living Waiver (0346) are evaluated and updated no less than annually by MHD and DSDS. The process includes the review of performance measures, reports for performance measures and remediation activities resulting from discovery. Annually MHD and DSDS will determine if the QIS is providing the information and improvements necessary to meet the quality assurance performance measures as it relates to discovery, remediation and improvement activities. The committee will evaluate the QIS process annually to determine if the process is working. If it is determined additional input is necessary, DSDS and MHD will request input from individuals involved in the authorization and/or delivery of ADCW, ADW, and ILW services. This could include providers, other stakeholders and/or DSDS and MHD staff from other units within the Divisions.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Providers are required to maintain financial records and service documentation on each waiver participant, including the name of the participant, the participant's MO HealthNet identification number, the names of the individual attendants who delivered the service, the date that the service was rendered, and the units of service provided. Services provided through the Independent Living Waiver must be prior authorized by DSDS 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 via an electronic system. The authorization is also provided to the provider selected by the waiver participant; therefore, the provider is aware of the authorization level and is better equipped to train the participant in time sheet maintenance, etc. Audits are performed by an independent auditor and submitted to the State agency annually.

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. A Remittance Advice indicating the disposition of billed claims is made available to the provider by MO HealthNet.

The Missouri State Auditor’s office conducts the audit in compliance with the Single Audit Act. The Missouri Medicaid Audit & Compliance (MMAC) Unit within the Department of Social Services (DSS) conducts compliance audits once every 3 years, in which the documentation of services provided is reviewed to ensure that services billed to MO HealthNet were provided and documented as required (13 CSR 70.3). Providers have the responsibility of

ensuring they have adequate documentation to support ILW services prior to the filing of claims to MO HealthNet for reimbursement.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of 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):
Record reviews, on-site
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 claims reimbursed at less than or equal to the Medicaid maximum in MMIS for the specified service. Numerator = Number of claims reimbursed at less than or equal to the Medicaid maximum in MMIS for the specified service. / Denominator = Total number of claims reviewed.

Data Source (Select one):
Record reviews, on-site
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:

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.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
State financial oversight exists to ensure claims are coded and paid in accordance with the reimbursement methodology in the approved waiver. Claims payment issues are the responsibility of MHD. MHD works to resolve payment issues as they are identified by MHD or DHSS. When an overpayment or underpayment has occurred, MHD recycles claims to pay or recoup appropriate funds. MMAC is responsible for provider reviews and identifying incorrect billings due to inadequate documentation, coding or unit errors or other findings. Remediation occurs through changes in policy, procedure or MMIS system edits or through the finalization of audits.

When payment issues are identified, MHD staff will 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 the Independent Living Waiver (ILW) services are based on the following factors; the Missouri hourly minimum wage, gas prices per gallon for the Midwest, the hourly amount for ILW services, the Consumer Price Index, in addition to the complex care needs of ILW participants. The reimbursement rate is subject to, and determined by, the State Legislature through the State of MO annual budgeting/appropriation process. Participants and business entities are able to testify at annual appropriation hearings conducted by the State House of Representatives and State Senate appropriation committees to provide input on reimbursement rates. The rates established by the MO Legislature are statewide rates; it does not vary by provider. Current reimbursement rates can be found on MO HealthNet's website at http://dss.mo.gov/mhd/providers/pages/cptagree.htm. Information regarding payment rates is available upon request by the participant, through the MHD Participant Services Unit or online at the MHD website. Requests may be made in writing to the MHD or DHSS, by e-mail to ASK MHD, or by phone call to the MHD Participant Services Unit.

The personal care service rate is based on 2 factors; the attendant's wages and applicable employer taxes. The personal care service rate is based on Missouri's Department of Labor and Industrial Relations CY 12 Average Wage for Personal Care and Service Workers plus all employer related taxes associated with the wage. Providers of Financial Management Service (FMS) act as agents on behalf of the participant and are responsible for all employer and employee payroll functions and requirements.

The reimbursement rate for FMS provided through the ILW is a statewide rate and is based on cost analysis associated with the provision of this service. In addition, industry standards and information from other states for reimbursement of FMS was considered. Missouri also consulted with ILW providers regarding costs associated with FMS. The hourly rate for the payroll clerk and a half-time supervisor is based on occupational and wage estimates from the Missouri Department of Economic Development, Missouri Economic Research and Information Center (MERIC). Fringe benefits include payroll taxes (FICA, Medicare, SUTA, FUTA); health insurance; retirement funds; vacation, and sick time; paid holidays; life insurance; educational assistance as well as other employee benefits. DSDS used 49%, which is the amount used by Department of Health and Senior Services to estimate the fringe benefit costs for its employees. The estimated administrative cost was calculated at 22.5% of the Personnel and Fringe Benefits costs.

The reimbursement methodology for the current rate for case management is the minimum of 12 hours X minimum wage + employer taxes. This service is consistent with the provisions of §1902(a)30(A) of the Act (i.e., payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers).

Regarding the reimbursement for Environmental Accessibility Adaptations and Specialized Medical Equipment and Supplies, the State requires three (3) estimates of the cost for the needed items. The State then reviews and approves one of the estimates. The State prior authorizes enough units to cover the actual cost of the item.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All services provided under this Waiver Program are prior authorized by Missouri Department of Health and Senior Services' (DHSS) staff. The prior authorization is forwarded to the MO HealthNet Fiscal Agent. Providers of services bill claims for services directly to the MO HealthNet Fiscal Agent for claims processing. All claims are processed through a MMIS. Claims are checked against services prior authorized. Only authorized services are paid. Any qualified Medicaid enrolled waiver provider may bill the state directly.

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:

DSDS staff determine participants' eligibility for waiver services and develop/finalize the service plan. Services are then prior authorized. This information is then transferred to the MMIS for establishment of a prior authorization against which all claims for payment from providers are compared. The MMIS system also incorporates an edit function that ensures services are only reimbursed to the provider for dates of service on which the participant is Medicaid eligible. The MMAC within the DSS conducts periodic compliance audits in which the documentation of services provided is reviewed to ensure that services billed to MHD were provided and documented as required (13 CSR 70.3). 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 reimbursment 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.**
- [x] **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:

Financial Management Services entities are designated as an OHCDS as long as they meet provider qualifications as specified in C- 3 and provide one service directly. Providers who meet the qualifications to enroll as an FMS may enroll directly and are not required to enroll as an OHCDS. Any qualified waiver providers who do not wish to contract with a Medicaid enrolled OHCDS may enroll directly with the Medicaid agency, through the normal provider application process. Direct service providers are not required to contract with an OHCDS. Participants have free choice of FMS providers both within the OHCDS and external to these providers. Participant may choose any qualified FMS provider to perform financial transactions on their behalf. The participant refers the attendant to the FMS provider of their choice to perform payroll functions. The participants have free choice of any qualified provider for the provision of a waiver service. The OHCDS is required to verify that the attendant with whom they contract meet the requirements specified in Appendix C for Attendant Care services. Qualifications of attendants are verified during provider reviews conducted by the Missouri Medicaid Audit and Compliance (MMAC) unit within the Department of Social Services, the Single State Medicaid agency. Quality oversight and monitoring of the OHCDS is administered by the Missouri Medicaid Audit and Compliance (MMAC) unit within the Department of Social Services, the Single State Medicaid agency. Reimbursement is based on a fee schedule or acquisition costs. For example, the State requires three (3) estimates of the cost for the specialized medical equipment and supplies (SMES) and Environmental Accessibility Adaptations (EAA) items, the state reviews and approves one of the estimates. The state prior authorizes enough units to cover the actual cost of the item. Attendant care services are reimbursed based on a statewide fee for service reimbursement rate. The reimbursement rate only includes the wages and applicable state and federal taxes. Financial oversight and monitoring of the OHCDS is administered by the Missouri Medicaid Audit and Compliance (MMAC) unit within the Department of Social Services, the Single State Medicaid agency.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a**

prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

○ **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The □1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☐ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The Department of Health and Senior Services (DHSS) is appropriated the state funds for the Independent Living Waiver. DHSS has filed an authorization letter with the Missouri Office of Administration indicating that MO HealthNet Division is approved to code the state portion of Mo HealthNet expenditures for the Independent Living Waiver against DHSS appropriations.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix**

C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8768.80	16734.00	25502.80	30698.00	6189.00	36887.00	11384.20
2	9074.00	17135.00	26209.00	31435.00	6337.00	37772.00	11563.00
3	9173.00	17547.00	26720.00	32189.00	6490.00	38679.00	11959.00
4	3897.31	17968.00	21865.31	32962.00	6645.00	39607.00	17741.69
5	3910.31	18399.00	22309.31	33753.00	6805.00	40558.00	18248.69

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	600	600
Year 2	600	600
Year 3	600	600
Year 4	600	600
Year 5	600	600

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.

Average length of stay is 155 days. This is based on average length of stay as determined through the calculation of the 372 report.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The current ILW population was reviewed to determine the percent of participants receiving each service. Average units per participant are based on actual service utilization data from CY 12 and actual ILW expenditures. This information was applied to the total slots available in the waiver renewal. The unit costs for each waiver service were projected forward using a 2.4% market basket rate increase for years 1-5 of the waiver application. The total projected expenditure was then divided by the unduplicated number of slots available.
Amendment for years 4 – 5 is based upon the projected change in total waiver participants due to increased level of care requirements, currently authorized users, and current rates. Currently there are 534 authorized waiver participants, which is a 351% increase from the previous 372 report showing 152 participants. Therefore, the state anticipates filling all 600 slots. No increase in unit rates was projected due to expected budget constraints. Utilization of service type is based upon current authorizations with an increase to 600 participants.

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:

In order to estimate the Factor D' value, the CY 12 actual cost for all other services while they were in the waiver was divided by the unduplicated number of participants. The amount was then projected forward using a 2.4% market basket rate increase. Part D drugs were no longer applicable to CY 12 actual expenditures.

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:

The factor G estimates are based on actual FY 11 paid claims for nursing facilities expenditures divided by the total unduplicated number of individuals who received nursing facility care. This resulted in the average aggregate cost per individual, for nursing facility care. This result was projected forward each year using a 2.4% market basket rate increase.

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:

The factor G' estimates are based on FY 11 actual paid claims history for all other Medicaid covered services while the individuals were in a nursing facility, divided by the total unduplicated number of nursing facility residents. This resulted in the average aggregate cost per individual for all other services while the individuals were in the nursing facility. This result was projected forward each year using a 2.4% market basket rate increase.

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	
Case Management	
Personal Care	
Financial Management Services	
Environmental Accessibility Adaptations	
Specialized Medical Equipment and 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
Case Management Total:						**60000.00**
Case Management	Annual	600	1.00	100.00	**60000.00**	
Personal Care Total:						**4695052.50**
Personal Care	1 unit = 15 minutes	450	2939.00	3.55	**4695052.50**	
				GRAND TOTAL:		**5261252.50**
				Total Estimated Unduplicated Participants:		**600**
				Factor D (Divide total by number of participants):		**8768.80**
				Average Length of Stay on the Waiver:		155

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:						**495000.00**
Financial Management Services	1 unit = 1 month	450	10.00	110.00	**495000.00**	
Environmental Accessibility Adaptations Total:						**400.00**
Environmental Accessibility Adaptations	1 unit equals $100	2	2.00	100.00	**400.00**	
Specialized Medical Equipment and Supplies Total:						**10800.00**
Specialized Medical Supplies	1 unit equals $100	14	6.00	100.00	**8400.00**	
Specialized Medical Equipment	1 unit equals $100	1	24.00	100.00	**2400.00**	
				GRAND TOTAL:		**5261252.50**
				Total Estimated Unduplicated Participants:		**600**
				Factor D (Divide total by number of participants):		**8768.80**
				Average Length of Stay on the Waiver:		155

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
Case Management Total:						**60000.00**
Case Management	Annual	600	1.00	100.00	**60000.00**	
Personal Care Total:						**4814082.00**
Personal Care	15-minute unit	450	2939.00	3.64	**4814082.00**	
Financial Management Services Total:						**504000.00**
Financial Management Services	1 unit = 1 month	450	10.00	112.00	**504000.00**	
Environmental Accessibility Adaptations Total:						**400.00**
Environmental Accessibility Adaptations	1 unit equals $100	2	2.00	100.00	**400.00**	
				GRAND TOTAL:		**5444482.00**
				Total Estimated Unduplicated Participants:		**600**
				Factor D (Divide total by number of participants):		**9074.00**
				Average Length of Stay on the Waiver:		155

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:						**66000.00**
Specialized Medical Supplies	1 unit equals $100	14	6.00	100.00	**8400.00**	
Specialized Medical Equipment	1 unit equals $100	24	24.00	100.00	**57600.00**	
				GRAND TOTAL:		**5444482.00**
				Total Estimated Unduplicated Participants:		**600**
				Factor D (Divide total by number of participants):		**9074.00**
				Average Length of Stay on the Waiver:		155

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
Case Management Total:						**60000.00**
Case Management	Annual	600	1.00	100.00	**60000.00**	
Personal Care Total:						**4919886.00**
Personal Care	15-minute unit	450	2939.00	3.72	**4919886.00**	
Financial Management Services Total:						**513000.00**
Financial Management Services	1 unit = 1 month	450	10.00	114.00	**513000.00**	
Environmental Accessibility Adaptations Total:						**400.00**
Environmental Accessibility Adaptations	1 unit equals $100	2	2.00	100.00	**400.00**	
Specialized Medical Equipment and Supplies Total:						**10800.00**
Specialized Medical Supplies	1 unit equals $100	14	6.00	100.00	**8400.00**	
Specialized Medical Equipment	1 unit equals $100	1	24.00	100.00	**2400.00**	
				GRAND TOTAL:		**5504086.00**
				Total Estimated Unduplicated Participants:		**600**
				Factor D (Divide total by number of participants):		**9173.00**
				Average Length of Stay on the Waiver:		155

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
Case Management Total:						**49100.00**
Case Management	Annual	491	1.00	100.00	**49100.00**	
Personal Care Total:						**2045984.85**
Personal Care	15-minute unit	195	2939.00	3.57	**2045984.85**	
Financial Management Services Total:						**214500.00**
Financial Management Services	1 unit = 1 month	195	10.00	110.00	**214500.00**	
Environmental Accessibility Adaptations Total:						**1800.00**
Environmental Accessibility Adaptations	1 unit equals $100	9	2.00	100.00	**1800.00**	
Specialized Medical Equipment and Supplies Total:						**27000.00**
Specialized Medical Supplies	1 unit equals $100	37	6.00	100.00	**22200.00**	
Specialized Medical Equipment	1 unit equals $100	2	24.00	100.00	**4800.00**	
				GRAND TOTAL:		**2338384.85**
				Total Estimated Unduplicated Participants:		**600**
				Factor D (Divide total by number of participants):		**3897.31**
				Average Length of Stay on the Waiver:		155

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
Case Management Total:						**49100.00**
Case Management	Annual	491	1.00	100.00	**49100.00**	
Personal Care Total:						**2045984.85**
Personal Care	15-minute unit	195	2939.00	3.57	**2045984.85**	
Financial Management Services Total:						**222300.00**
Financial Management Services	1 unit = 1 month	195	10.00	114.00	**222300.00**	
Environmental Accessibility Adaptations Total:						**1800.00**
Environmental Accessibility Adaptations	1 unit equals $100	9	2.00	100.00	**1800.00**	
Specialized Medical Equipment and Supplies Total:						**27000.00**
Specialized Medical Supplies	1 unit equals $100	37	6.00	100.00	**22200.00**	
Specialized Medical Equipment	1 unit equals $100	2	24.00	100.00	**4800.00**	

GRAND TOTAL:	**2346184.85**
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**3910.31**
Average Length of Stay on the Waiver:	155