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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
Significant changes to the approved waiver being made in this renewal application are as follows:

Professional Assessment and Monitoring services (PAMS) was removed since it is has not been utilized in the Missouri Children with Developmental Disabilities (MOCDD) waiver since the service was added at the last waiver renewal, as indicated in the 372 Reports from Fiscal Years 2014 and 2015. Nursing services are provided through EPSDT for children under 21. Children in this waiver have access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

The division is proposing to change the waiver cycle years to July through June to align with other division waivers. Any changes in these waivers will be implemented upon CMS approval.

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*):
Missouri Children with Developmental Disabilities (MOCDD) Waiver

C. **Type of Request: renewal**

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MO.40185
Waiver Number:MO.4185.R05.00
Draft ID: MO.005.05.00

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

Regular Waiver

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

07/01/18

Approved Effective Date: 07/01/18

1. Request Information (2 of 3)

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

Medicaid State plan (*check each that applies*):

- [ ] **Hospital**

  Select applicable level of care

  - ( ) **Hospital as defined in 42 CFR §440.10**

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

    [ ]

  - ( ) **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

- [ ] **Nursing Facility**

  Select applicable level of care

  - ( ) **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

    If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

    [ ]

  - ( ) **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

- [x] **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

  [ ]

1. Request Information (3 of 3)

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

Select one:

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

  Check the applicable authority or authorities:

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

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

    [ ]

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

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

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

    [ ]

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

    Specify the program:

    [ ]

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
GOAL: Establish and maintain a community based system of care for children with developmental disabilities that includes a comprehensive array of services that meets the individualized support needs of children to allow them to remain at home with their families rather than enter an institution, group home or other out of home care.

OBJECTIVES: 1) provide families choice between ICF/ID institutional care and comprehensive, cost effective community based care; 2) maintain and improve a community based system of care that diverts children from institutional care and residential care; 3) maintain and improve community based care so services are sufficient to support children living at home with their family; and 4) provide choice and flexibility within a community based system of care.

Children in this waiver are living at home with their family but require services and supports so that family members can continue employment and primary caregivers can access relief. This waiver allows certain State MO HealthNet eligibility requirements to be waived so that children targeted for participation may be determined MO HealthNet eligible. In Missouri, the income and resources of a child's parents must be considered in determining the child's financial eligibility for MO HealthNet when the child lives in the home with the parents. This requirement called deeming parental income to the child is waived for children who participate in the waiver. For these children, financial eligibility for MO HealthNet is determined solely on the income and resources of the child.

The waiver is administered by the Division of Developmental Disabilities (DD) through an interagency agreement with the Department of Social Services, the Single State Medicaid Agency. Division of DD has 6 Regional Offices with 5 satellite offices (herein referred to as Regional Offices) that are the gatekeepers for the waiver. The Regional Offices determine eligibility, provide case management, and other administrative functions including quality enhancement, person centered planning, and operation of prior authorization and utilization review processes. Through contracts administered by the Department of Mental Health, SB-40 Boards (public entities) and other Targeted Case Management (TCM) entities provide limited waiver administration functions (case management) in coordination with Regional Offices and oversight from the Division of DD.

Service delivery methods in this waiver include provider-managed (for all waiver services); and there is a self-directed option for personal assistant and community specialist.

Each waiver provider has a contract with the Division of DD. Division of DD Regional Offices authorize services to the providers. Providers must bill through the Division of DDs prior authorization system. The Division of DD submits the qualified bills to the Medicaid claim processing fiscal agent. The Medicaid MMIS pays the providers directly for services provided.

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:
Division leadership meets on a regular basis with formal stakeholder organizations including the DD Council, The Missouri Chapter of Arc, Missouri Association for County Developmental Disability Services, the Missouri Association of Rehabilitation, the SB 40 TCM Workgroup, and the Governor's Council on Disabilities, and solicits input on all four DD waivers from these groups on an ongoing basis. Locally, Regional leadership meets regularly with providers of waiver services, TCM providers and local Regional Advisory Councils.

The division also posted the waiver application on the website for additional stakeholder input.

Stakeholders were invited to participate in a public forum that was held:
February 20, 2018
9 a.m. to 11:00 a.m.
James C. Kirkpatrick State Information Center Interpretive Center
600 W. Main Street, Room 139Jefferson City, MO 65101

Public comment was taken from February 9, 2018 through March 11, 2018.

Hard copies of the waiver renewal application were available at each of the Division of DD Regional Offices and also available at the public forum held on February 20, 2018.

A Pediatric Home Health Provider
Missouri Association of County Developmental Disabilities Services (MACDDS), which is comprised of 65 county boards and 19 Related Private Organizations that provide local services for people with developmental disabilities.

The following addresses the questions, comments, and letters received during the public forum and public comment period.

Appendix B Participant Access and Eligibility - Comments and questions in this section center on the requirements of Appendix B of the waiver application regarding target group(s) of Medicaid beneficiaries that the waiver serves, its scope (i.e., how many persons the waiver serves), and processes associated with entry into the waiver. No changes were made to the waiver application as a result of any comments in this section. There was one comment received for Appendix B.

Individual comment: Can there be a parental income cap or income asset based decision on the MOCDD waiver so when families' stature improves then they can leave the waiver? This would allow the waiver be given to other families with more needs? There are so many children that need the MOCDD waiver and most children remain in the waiver until they age out at 18.
Response: No, because considering parental income and resources is waived for children who participate in the MOCDD waiver. The financial eligibility is determined solely on the income and resources of the child. It is required for individuals that participate in the waiver to be assessed and re-determined annually to still be eligible for the waiver and have identified needs that can only be met through the waiver.
Appendix C Participant Services – Comments in this section center on the requirements of Appendix C of the waiver application

regarding the services that are provided in the waiver. No changes were made to the waiver application as a result of any comments in this section.
Comment: The proposed change that impacts beneficiaries and providers is the new limitation on Community Integration. Community Integration is a home and community based service designed to assist or teach participation in community activities such as "becoming a member of social events/clubs, recreational activities, volunteering, participating in organized worship or spiritual activities." The purpose of the benefit is to encourage persons with disabilities to engage and interact in the community with persons who are not paid to provide services to them. In the prior renewal of the DD Comprehensive Waiver, this benefit was limited to 25 hours/week, but in a provider bulletin dated March 23rd, 2017, the Division added another limitation of no more than five hours per day. The overall limit of 25 hours/week was not changed, but a daily limitation was added. (See MoHealthNet Division Provider Bulletin – Volume 39 Number 43, dated March 23rd, 2017.) As providers, we understand the need and authority of the Division to impose reasonable limitations, but to add another layer of restriction to this service, which has no impact on the cost to the program since the weekly limit has not changed, only serves to impact the ability of the individual to fully engage in his/her community. Further, this limitation imposes an unequal burden on beneficiaries and providers in rural areas where engagement in community activities frequently involves considerable travel time.
Response: There is no change in the 25 hour per week limit for Community Integration service in the PFH and MOCDD renewals. This limit is in all of the Division's CMS approved Waiver applications. MO HealthNet's billing system currently allows for daily limits, not weekly limits. The Division will work with providers and individuals who need to exceed 5 hours of Community Integration service in one day to ensure appropriate services and billings can occur.
Comments: General comments about Medicaid state plan services including private duty nursing and personal care were received.
Response: No response needed as this was not related to the waiver application renewal.

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, Program Operations

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) 751-6962 **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: Brenner

First Name: Angela

Title: Director of Federal Programs

Agency: Missouri Department of Mental Health, Division of Developmental Disabilities

Address: 1706 East Elm

Address 2: PO Box 687

City: Jefferson City

State: **Missouri**

Zip: 65102

Phone: (573) 526-1853 **Ext:** ☐ **TTY**

Fax: (573) 751-9207

E-mail: Angela.Brenner@dmh.mo.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Debbie Meller

State Medicaid Director or Designee

Submission Date: Jul 17, 2018

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

Last Name: Tidball

First Name: Jennifer

Title: Acting Director

Agency: Department of Social Services, MO HealthNet Division

Address: 615 Howerton Court

Address 2: P.O. Box 6500

City: Jefferson City

State: **Missouri**

Zip: 65101

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

Fax: (573) 751-6564

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

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- [ ] **Replacing an approved waiver with this waiver.**
- [ ] **Combining waivers.**
- [ ] **Splitting one waiver into two waivers.**
- [x] **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:

Professional Assessment and Monitoring services (PAMS) was removed from the waiver services. No individuals will be affected by this change because this service was not utilized in the MOCDD waiver.

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

The state assures that the settings transition plan included with this waiver renewal 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 Home and Community-Based Service Settings Transition Plan Public Comments

This document contains a summary of the public comments collected in response to the Revised Missouri Statewide Transition Plan (STP) for the Home and Community Based Services (HCBS) Final Rule which amends the previous Statewide Transition Plan posted on December 24, 2014. Public comment was taken from July 29, 2016 through August 28, 2016. A notice regarding the revised Statewide Transition Plan was posted in The Columbia Tribune, Independence Examiner, Kansas City Star, Springfield News-Leader and The St. Louis Post Dispatch on July 29, 2016. A complete copy of the Revised State Transition Plan is available at each of the DMH Regional Offices, the Department of Health and Senior Services Regional Evaluation Team (REV) offices, or by request. In accordance with Centers for Medicare and Medicaid Services (CMS) guidance, the Revised State Transition Plan was made available for 30 day public comment to allow all consumers, providers and stakeholders an opportunity to provide input to the revised plan. Additionally, Braille copies were available upon request.

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

Parent advocates
Family members
Protection & Advocacy Organization

Missouri Developmental Disabilities Council (MODCC)

Seven letters were received from parent advocates, family members, and Protection & Advocacy Organization. No changes were made to the Statewide Transition Plan as the result of any comments in this section.

Comment: Three of the letters reflect the concern for the freedoms of individuals' including their rights, choice and person-centered planning which should include access to services and supports without restrictions in HCBS funding. Individual's experience and choice including that of the guardian or family member should be accepted. There was concern regarding the provider assessment and the importance of communication with the stakeholders within the organization/business including clients, families, guardians and staff.

The comments focused on individuals' "choice" and having meaningful lives in whatever community they choose to live in. The assessment process with interviewing individuals should have verification of individuals experience and choice being offered. The provider self-assessments should have verification. One comment included the suggestion of more choice like community, farm, intentional or whatever they choose, not what the government chooses.

Response: Any setting in which HCBS are provided is required to be compliant with the HCBS rule for all services provided in the setting. The DMH individualized assessment process will determine if the individual's choices and needs are met and are supported and documented in their Person-Centered Plan. All provider self-assessments are verified through the on-site individual assessment process with the individual. The individual's on-site assessment includes information and evidence from the individual, and family/guardian, if the individual chooses, regarding their experiences with personal choice, wants, and needs.

Comment: One of the letters received expressed satisfaction with the comprehensive waiver services. Because of the waiver, they are able to have their family member at home with them and get the care needed. The family member is able to get the privacy and the freedom needed, as well as the ability to go out in the community. There is not a limit to do certain things.

Response: No response necessary.

Comment: One letter indicated that the DMH survey does not do a good-enough job of asking the right questions. The HCBS rules should be explained and attached, and should be easy to read and comprehend. Regarding the DHSS survey, a contact for the Department of Health and Senior Services and a phone number should be listed in case the participant, or the individual helping the participant fill out the survey, has questions.

Response: The DMH survey included CMS exploratory questions modified for easy read. DMH developed and distributed easy read documents about the HCBS rule. These documents were distributed at self-advocate conferences and at individual on-site assessments. The documents are also located on the DMH website at: https://dmh.mo.gov/dd/hcbs.html. DHSS does not plan to continue the original survey process. On an ongoing basis, HCBS participants will receive an annual reassessment, during which information regarding the HCBS Settings regulations will be provided and the participant will be given the opportunity to give feedback and express concerns. The participant will receive a copy of this information which will include the contact information for their local office. Additionally, any new participants will be given this information prior to starting services.

Comment: Several letters were regarding the Participant Survey stating it should be the most important assessment tool while evaluating HCBS Waiver programs. There was concern about greater outreach needed to get accurate markers of community involvement in person-centered planning. There was also concern that the Provider Self-Assessment Survey results were not available yet. There was a question as to why the surveys do not ask for comments or feedback from the participants?

Response: The Participant Survey is a component of the entire review process. Individual on-site assessments are performed to obtain information and evidence about the individual's experience, community involvement, and choice in settings, services and providers. Participant's surveys are considered in the individual's on-site assessment and in the provider self-assessment validation process. DMH distributed participant surveys through a variety of sources, such as on-line at http://dmh.mo.gov/dd/hcbs.html , through its DMH Support Coordinators during monitoring visits, at a variety of stakeholder conferences (People First, MACDDS and Real Voices, Real Choices), and stakeholder list serves (Partners in Policy Making). The provider self-assessment survey results will be posted. DHSS participant surveys were sent to all Adult Day Care participants and the surveys did request comments and feedback following each question. The survey can be located at: http://health.mo.gov/seniors/hcbs/transitionplan.php

Comment: There was a question regarding where in the transition plan it mentions the accommodation for the individuals who may be, displaced because of non-compliance with the HCBS regulations.

Response: The Individuals Transition to Settings that Align with HCBS Requirements section of the STP describes the process for individuals in settings that are not HCBS compliant. Provider settings must be in compliance by March 2019 in order to continue receiving HCBS funding. If a provider has not come into compliance and relocation of individuals is necessary, the State will work with the individuals to ensure they are transitioned to settings meeting HCBS Setting requirements. The public can review pages 30 and 32 of the Amended Transition Plan to find this information.

Comment: A few comments about the Waiver Service are individuals with autism deserve access to the HCBS that will benefit them and will meet their particular needs; individuals with autism who receive HCBS have difficulty finding providers that can address their complex and challenging needs; True integration is only possible if the state reimburses for HCBS based off rate structures and billing guidelines that are

tied to the individual's need and not based off the place they live or receive services; The state needs to show how reimbursements will be tied to individual need and not the provider.

Response: The State has always and will continue to work to ensure provider capacity and service settings to meet the needs of individuals. Waiver service reimbursement methodologies are included in the waiver applications in Appendix I.

Six letters were received from individuals who are affiliated with Missouri Developmental Disabilities Council (MODDC):

The template letters were created for input from advocates and HCBS participants to ensure HCBS participants receive the benefits of, and are fully included, in the broader community. The following summarizes the six template letters. The letters requested clarity while highlighting concerns and answers for the following areas: Stakeholder Involvement; Use of Participant Surveys; The Provider Assessment Process and Other Problems in the State Transition Plan. No changes were made to the Statewide Transition Plan as the result of any comments in this section, unless otherwise noted below.

COMMENT: The State STP seems to focus on providers rather than focusing more on HCBS participants, their experiences, and their ideas about what needs to change. The state should do more with the STP plan and really look at the problems in our HCBS programs that prevent people with disabilities from being a part of their community and having control of their lives, with support from the programs.

Response: The state's intent with the HCBS rule and transition is to be person-centered throughout all processes. As part of the transition plan, the experience of the individual is central to the comprehensive review of the state delivery system and is an ongoing process. The STP is a vehicle through which the state assesses individual experiences and state/ provider systemic compliance. CMS requires that the STP detail specific steps that must be taken on the state and provider level in order to make systemic changes that impact an individual's experience. The information gathered from the individual assessments is used to develop the remediation and changes with the state's and providers' systemic policies and procedures. The state added language in the Comprehensive Waiver description to clarify choice is for services and providers. The state also added language in the introduction that 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.

COMMENT: The state should involve more from stakeholders and more effort into talking to people with disabilities and other people affected by the HCBS waivers, such as families. Although the state has put the STP out for public comment, it is not always easy to know when the plan is out for comment and have enough time to read it and write comments.

Response: The state has kept waiver participants as the focus in all aspects. Approximately 1,100 Waiver participants throughout the state were called individually to schedule HCBS assessments based on results of a random sample and heightened scrutiny mapping. The state accommodated assessment times with the waiver participants' schedules including before and after business hours. These assessments were conducted at the participant's setting and in private based on their preference. Families and Guardians were contacted with the date and time of the assessments and had the option to participate in the assessment if the waiver participant and family desired. DMH staff conducted on-site, face-to-face assessments with individuals, guardians, and others chosen by the individual utilizing the DMH Assessment Tool. DMH distributed participant surveys through a variety of sources, such as on-line at http://dmh.mo.gov/dd/hcbs.html , through its DMH Support Coordinators during monitoring visits, at a variety of stakeholder conferences (People First, MACDDS and Real Voices, Real Choices), and stakeholder list serves (Partners in Policy Making).
The DMH HCBS stakeholder workgroup consists of individuals from MODDC, MACDDS, MARF, Missouri P&A, People First, individual providers, self-advocates and families. Participants of the stakeholder workgroup may share the STP with their stakeholders and provide feedback to the workgroup prior to public comment. In addition, MO HealthNet sends notices out to anyone signed up for their email listserve notifying stakeholders of STP public comment periods. DMH forwards the MO HealthNet email to all individuals signed up for the DD email listserve. Newspaper notices were sent out to the 5 major newspapers across the state. Complete copies of the revised Transition Plan are available at each of the DMH Regional Offices, the Department of Health and Senior Services Regional Evaluation Team (REV) offices, or by request. The State and the DD Council will continue to explore opportunities to ensure that individuals and families receive and understand information regarding the HCBS rule, and that they are a part of system changes. The previous sentence was added to the Public Comment section of the STP.

COMMENT: The state is not doing much to help HCBS participants understand the rules and the changes that might happen. The changes were difficult to understand.

Response: The Division has taken numerous steps to ensure HCBS waiver participants understand the HCBS rule and changes. State assessors educated individuals and families about the HCBS rule before and during the assessments and answered any questions or concerns that individuals and families had. Information was distributed during HCBS assessments with websites and contact information should they have any questions at a later date. State staff educated individuals and families at conferences. Support Coordinators and providers have been educating individuals and families. The division will be providing additional HCBS training in the coming months. Several easy read documents for individuals and families may be found on the divisions HCBS website at https://dmh.mo.gov/dd/hcbs.html. The Division and the DD Council will continue to explore opportunities to ensure that individuals and families receive and understand information regarding the HCBS rule, and that they are a part of system changes.

COMMENT: The evidence the state is planning to submit for heightened scrutiny settings is concerning. The state is planning to focus the evidence only on the positive, community-based aspects of a setting. The evidence would be incomplete if the institutional qualities of the setting are never identified. If we do not know what was bad about the facility, how can we tell if the setting has overcome those issues?

Response: Individuals are informed if their setting is heightened scrutiny through the assessment process. There will also be further guidance coming from CMS regarding identification of heightened scrutiny settings either via on-line posting or letter notification. The state will use individual experiences as evidence for a heightened scrutiny setting's compliance with the HCBS rule. Individuals receive the provider's Summary of Findings report as a result of the individual on-site assessment. Evidence packages submitted to CMS will include information from the individual, family/guardian, provider remediation, and from the local community. Evidence submitted to CMS for heightened scrutiny settings is only for those providers that the state deems compliant with the HCBS rule, per CMS guidance. The state is in the process of writing a report that explains the overall findings for all assessments including heightened scrutiny. The report will detail areas of non-compliance. DMH will continue to work with providers to become compliant with the HCBS Settings rule between March 2, 2015 and March 17, 2018. Individuals in a non-compliant setting as of March 17, 2018 will begin the transition process to a compliant setting. Please see Individuals Transition to Settings that Align with HCBS Requirements section for further details.

COMMENT: The STP indicates that the regulatory review was undertaken to "allow the State to operate HCBS programs in a manner that comports with the HCBS Final rule." The regulatory review should also consider how the code of state regulations could be improved to support the final rule to the maximum extent possible. Strong regulatory language would help ensure families.

Response: The STP contains a crosswalk of system policy, procedures, manuals, waivers, & state regulations which outlines what the state will revise and implement in order to come into compliance with the rule. The crosswalk link can be found in the STP on page 8.

COMMENT: Participant surveys are one of the important pieces of the STP for identifying problems in the HCBS programs. It is important that a person understands the HCBS rules before they are asked to take a survey about the HCBS rule. The DMH survey did not do a good job of asking the right questions. The questions may have been asked with providers and some participants may be intimidated to answer questions in certain ways in order to receive positive comments. This could lead to inaccurate responses.

Response: The DMH survey included CMS exploratory questions modified for easy read. DMH developed and distributed easy read documents about the HCBS rule. These documents were distributed at self-advocate conferences and at individual on-site assessments. The documents are also located on the DMH website at: https://dmh.mo.gov/dd/hcbs.html. The intent of the state was for individuals, families, and/or guardians to complete the participant surveys. State staff also offered to assist individuals in completing participant surveys.

The Division has taken numerous steps to ensure HCBS waiver participants understand the HCBS rule and changes. State assessors educated individuals and families about the HCBS rule before and during the assessments and answered any questions or concerns that individuals and families had. Information was distributed during HCBS assessments with websites and contact information should they have any questions at a later date. State staff educated individuals and families at conferences. Support Coordinators and providers have been educating individuals and families. The Division and the DD Council will continue to explore opportunities to ensure that individuals and families receive and understand information regarding the HCBS rule, and that they are a part of system changes.

COMMENT: The on-site assessment section of the STP has many positive features, including face-to-face assessments. However, the choice to summarize the results of the assessment process creates room for bias to influence the overall assessment of a setting. The assessments need to be very robust, and focus on the individuals' opinions of their experience in the setting. The state does not describe any process for quality reviews of the summaries to determine if a person summarizing the results has done so accurately or if there are differences in the information, such as from a provider and from a participant, whether that difference was noted or otherwise resolved in a way that would hide relevant information regarding noncompliance.

Response: The summaries of the on-site assessments are mailed to the individuals and providers. Individuals can provide feedback and comments to the summary of findings. Providers are required to respond with proposed remediation to the findings noted.

COMMENT: The provider self-assessment process is not usually a very reliable approach to identifying a problem. Providers will not indicate if they are doing a bad job. The assessment was optional for providers, and the assessment tool was very basic. In addition, providers were not encouraged to submit the self- assessments, because the state said it would perform onsite assessments of some of the providers who completed the survey, and that the surveys would be reviewed before a provider compliance review.

Response: The provider self-assessment Survey was open for a period of time August 21, 2014 through September 10, 2014 as indicated in the MO HealthNet Provider Bulletin dated August 22, 2014. The State also sent notices to providers on June 23, 2014, with a follow-up notification sent in August 2014. DMH attend provider association meetings to educate providers on the provider self-assessment survey request and the importance of completion. 100% of the provider self-assessment surveys received are validated through the individual's on-site assessment.

COMMENT: The state needs to make sure surveys are filled out by HCBS participants every year so they get a response from most people, not just the few who choose to respond. Every waiver participant should be asked to take the survey and they should get any assistance they need to understand it.

Response: The HCBS survey questions have been incorporated into ongoing monitoring processes which include all waiver participants. The Ongoing Compliance/Monitoring Review section of the STP describes the process to incorporate requirements of the HCBS Setting Rule into existing review processes and quality integrated functions: Provider Relations Reviews; Quality of Service Reviews including National Core Indicator Survey; Targeted Case Management Technical Assistance Coordinator Reviews; Service Monitoring by Support Coordinators; Licensure and Certification Reviews; and the CIMOR EMT Contacts Process which includes anonymous input from individuals served and their advocates. The quarterly/annual monitoring processes include on-site, face to face assessments with waiver participants about their HCBS

services.

COMMENT: The process for stakeholder input in the heightened scrutiny process is not very clear. I think it is very important that the state's assessment of each setting's compliance with the rules is public so that we can tell the state if we think an assessment of a setting is incorrect. We understand that the state likely cannot know everything about every setting.

Response: The federal HCBS definition of a heightened scrutiny setting is any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless CMS determines through the heightened scrutiny process, based on information presented by the state or designated party, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based.

The State Transition Plan indicates that the state will engage stakeholders, advocacy organizations, and providers in the heightened scrutiny review process and include this information as a part of the evidentiary package submitted to 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. The heightened scrutiny process will also engage stakeholders, advocacy organizations, and providers through the public comment and forum process.

COMMENT: The state does not talk about making sure we have more settings to choose from as other settings change. HCBS participants are supposed to have the choice of a non-disability specific setting and we do not have enough of those settings now for people to have that choice. Also, we will likely need new providers to take over for providers that do not want to meet the rules.

Response: Individuals have freedom to choose where they live within their available resources. The State has always and will continue to work to ensure provider capacity and service settings to meet the needs of individuals.

Comment: The other piece of the plan that is missing is there is no way for participants or their families to complain about a provider not following the HCBS rules. There should be a way an individual can complain about a setting violating the rules and receive a meaningful response to that complaint.

Response: The Ongoing/Monitoring Review section of the STP explains that DMH will include the DMH website URL on the Client Rights brochure and a statement in regards to the ability to make anonymous reports to Office of Constituent Services (OCS). The Division Individual Rights document will include a statement in regards to the ability for individuals to file anonymous reports to OCS. The DMH Client Rights brochure and other information regarding consumer rights and abuse/neglect is posted on this web site. The site also has a consumer safety video which discusses abuse and neglect and the reporting and investigation process, as well as the brochure Keeping Mental Health Services Safe which is a written version of the video. In the Frequently Asked Questions section on the website it does state and answer the question: What should I do if I suspect that a mental health client or family member may have been the victim of abuse or neglect? You may call the toll free number at 1-800-364-9687 and ask for the Office of Constituent Services. The office encourages everyone to make the contact for the safety of all clients. All calls will be kept confidential and the caller can choose to remain anonymous.

COMMENT: I think it is good that providers are going to be trained on the HCBS rules, but I think it would be helpful if waiver participants and other stakeholders were part of the training or at least had input on the trainings.

Response: DMH is in the process of developing additional trainings and will continue to work with DD Council and waiver participants to explore opportunities to ensure that individuals and families are a part of training and system changes.

COMMENT: The state should be encouraged to make providers meet the rules as soon as possible so there will be time to address any problems and help people find new settings. People need a lot of time to find a new place to live or to spend the day. The rules require that there be choice, so this decision should not be limited or rushed. We also need to make sure people get plenty of assistance in trying to find new settings.

Response: Per the Provider Individual Remediation and Provider Remediation Status Updates sections of the STP, DMH will continue to work with providers to ensure compliance with the HCBS Settings rule between March 2, 2015 and March 17, 2018. Individuals in a non-compliant setting as of March 17, 2018 will begin the transition process to a compliant setting. DMH will require all providers with remediation/transition plans to submit monitoring updates on a quarterly basis. The process for tracking and monitoring provider remediation plans will include monitoring provider transition plans by central office staff based upon milestones submitted and accepted by the department, during routine Provider Relations Reviews, Quality of Service Reviews to include National Core Indicator Surveys, TCM Technical Assistance Coordinator Reviews, Service Monitoring by Support Coordinators, and Licensure and Certification Reviews. A tracking spreadsheet that identifies the provider transition plan milestones and deliverable dates will be used to help coordinate this effort. The central office staff will monitor evidence submitted by the providers in relation to their approved milestones. Technical assistance will be provided if there is a problem with the implementation of the remediation plan, if providers are not implementing the plans or if the providers decide to significantly change their plans or the implementation of their plans. Status updates will occur between March 2, 2015 and March 17, 2018.

COMMENT: The STP does not give information about the due process rights that will be provided if a person is faced with the choice between not moving and giving up waiver services.

Response: Individuals Transition to Settings that Align with HCBS Requirements section within the STP indicates that individuals will be given timely notice and due process, 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.

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 Mental Health (DMH). The Department of Mental Health is the operational entity for the waiver.

The formal cooperative agreement outlines specific duties related to the administration, operation and oversight functions of the waiver. MHD 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 MHD prior to submission to CMS. Any changes to a waiver program must be approved by MHD. 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. This transition plan is specific to the Missouri Children with Developmental Disabilities Waiver (MO.4185) and is consistent with the statewide transition plan submitted to CMS on October 4, 2016. The transition plan has been jointly developed by the Department of Social Services/MO HealthNet Division and the DMH.

The MO Department of Mental Health operates the following 1915 (c) Waiver (DMH Waiver):

• Missouri Children with Developmental Disabilities Waiver (MO.4185)
o The Missouri Children's Developmental Disabilities Waiver (MOCDD) allows certain State MO HealthNet eligibility requirements to be waived so that children targeted for participation may be determined MO HealthNet eligible. This waiver terminates on the individual's 18th birthday, the date on which the participant becomes eligible for Medicaid based on age. This waiver establishes and maintains a community-based system of care for children with developmental disabilities that includes a comprehensive array of services that meets the individualized support needs of children to allow them to remain at home with their families rather than enter an institution, group home or other out-of-home care.

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.

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). 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:

• Structure of the STP: The format of the STP was changed from a table format to a narrative format, as well as clearly separating sections that apply exclusively to waivers operated by DHSS and those operated by DMH. It includes further descriptions and indication of setting types for each of the 10 waivers, and further clarification of the operating structure of DHSS waivers.

• 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 DMH 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. DMH 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 DMH located in: Missouri 13 CSR 70, Missouri 13 CSR 65-2, and Missouri 9 CSR 45.

o DMH's systemic CSR review included regulations concerning licensure and certification, provider enrollment, prioritizing access to funded services, the utilization review process, due process, standards for community-based services, individualized habilitation plan procedures, advisory councils for DMH departments authorized to license Medicaid-reimbursed HCBS settings. http://dmh.mo.gov/dd/hcbs.html
o DMH initiated ongoing internal strategy meetings to assess all rules and regulations. Additionally, DMH obtained consumer and family, provider, advocate, and other stakeholder input into revisions necessary based on the self-assessment of state standards, requirements and practices. DMH presented revisions to consumers, families, caregivers, providers, advocates, and other stakeholders via postings and comment periods. During these comment periods, DMH asked for stakeholder input on the development of the rules, regulations, policies, protocols, and practices. Instructions for providing input were included in the notices.

Provider Manuals, Policies, and Procedures Assessment
MHD requested DMH to review all manuals, policies, and procedures to determine their 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. DMH 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://dmh.mo.gov/dd/hcbs.html.

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.

DMH distributed participant surveys through a variety of sources, such as on-line at http://dmh.mo.gov/dd/hcbs.html , through its DMH Support Coordinators, at a variety of stakeholder conferences (People First, MACDDS and Real Voices, Real Choices), and stakeholder list serves (Partners in Policy Making). Results of the initial survey are posted on-line at http://dmh.mo.gov/dd/hcbs.html.

On an ongoing basis, questions posed from the participant surveys will be incorporated into annual assessments and reviews.
o DMH Quality Enhancement team incorporated Home and Community Based federal rules into the annual review process. The Quality of Services Review prescribes a standardized procedure to ensure the individual has full access to benefits of community living and the opportunity to receive services in the most appropriate integrated setting; assess the person-centered planning process; and provide feedback to the interdisciplinary team about utilizing key points of self-determination:
Individuals will live a meaningful life in the community and be empowered in making life decisions.
Individuals will have support to organize resources in ways that are life enhancing and assist them in reaching their dreams and goals.
Individuals have a circle of supports made up of family, friends, and both paid and unpaid supports.
Individuals assume responsibility for giving back to their community, for seeking employment, and for developing unique gifts and talents.

Individuals are recognized for who they are and what they can contribute.
Enhancing identified areas (values, choice, health, safety, inclusion, self-advocacy)
Reviews are conducted related to quality indicators based on the HCBS rule, Missouri Quality Outcomes http://dmh.mo.gov/dd/docs/missourqualityoutcomes.pdf, National Core Indicators http://www.nationalcoreindicators.org/indicators/, and 9 CSR 45-5.010 Certification of Medicaid Agencies Serving Persons with Developmental Disabilities.

o DMH incorporated Home and Community Based federal rules into the annual planning process utilized for all DMH HCBS waivers. The annual plan shall be face-to-face with the participant utilizing the Individual Support Plan Guide (http://dmh.mo.gov/dd/manuals/docs/ispguidenew.pdf) and Medicaid Waiver, Provider, and Services Choice Statement (http://dmh.mo.gov/docs/dd/revisedmedicaidwaiverproviderandserviceschoicestatement.pdf) to establish continued HCBS services and compliance with the HCBS Settings Rule.

The Individual Support Plan (ISP) Guide is a comprehensive guide to care and service planning in community-based settings. It focuses on the individual's strengths, capacities, preferences, needs and personal outcomes which include a personalized mix of paid and non-paid services and supports that will assist the person to achieve personally defined outcomes. Additionally, this guide has been updated to match the new Missouri Quality Outcomes, which were updated August 2015. The Missouri Quality Outcomes (MOQO) were developed to emphasize quality of life for individuals receiving services and supports; they are key to facilitating discussion during the Person Centered Planning process and developing the ISP. MOQO includes the different life domains that everyone experiences as we age and grow. Everyone (whether they have a disability or not) has to decide: what they are going to do during the day–go to school, volunteer or get a job; where they are going to live; how they are going to stay healthy and safe; and etc.

The ISP and Medicaid Waiver, Provider, and Services Choice Statement provides documentation of the individual's involvement in care planning by including the individual's acknowledgement and outcome of his/her:
• Participation in the development of the ISP
• Right to have anyone involved in the development of the ISP
• Right to choose and receive HCBS (State Plan and/or Waiver) or institutional care
• Right to choose the HCBS provider
• Right to Due Process

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. In addition, links to the provider self-assessment surveys were posted on the DMH website for provider access. DMH performed on-site assessments on all providers that completed an initial self-assessment to validate responses.

MHD requires DMH 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 A provider self-assessment survey was developed to identify HCBS sites and to gather additional information from providers to assess sites of service that have characteristics of HCBS or the qualities of an institution.
o As a result of provider feedback, DMH developed a Provider Survey Self-Assessment Companion Guide to offer further explanation of the Home and Community Based Setting Requirements. This companion guide follows the On-site Assessment Tool.
o The provider self-assessment is available on the DMH website for all prospective and currently enrolled providers to utilize at any time (http://dmh.mo.gov/dd/hcbs.html).
o DMH will re-post the provider self-assessment survey and the Provider Survey Self-Assessment Companion Guide to the DMH website annually on January 1 and encourage providers to complete the provider self-assessment by April 1, with results compiled by May 15.
o DMH will receive any completed annual provider self-assessment and maintain them in the providers' files.
o Components of the provider self-assessment tool have been incorporated into tools utilized when DMH completes provider monitoring and certification. DMH completes a Provider Relations review every three years. Certification occurs every two years when applicable.
o DMH will review any submitted provider self-assessments prior to provider relations reviews to determine if there are any potential compliance issues. DMH provider relations reviews occur every three years for specified services.
o DMH will review any submitted provider self-assessment in conjunction with the provider's DMH generated annual trend report to determine if there are any potential compliance issues. Any discrepancies will be followed up by the means necessitated by the level of concern (e.g. provider technical assistance, an on-site visit with the provider, placement on a provider improvement plan.)
o DMH will utilize the provider self-assessment as a training tool annually at Regional provider meetings.

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. Please note: residential habilitation settings include Group Home, Individualized Supported Living (ISL), and Shared Living. Non-residential settings include Day Habilitation and Employment.

Settings Assessed:
o Residential Habilitation, only provided in the Comprehensive Waiver
o Employment Services, only provided in the Comprehensive, Community Support, and Partnership for Hope Waivers
o Day Service, provided in all waivers except Autism Waiver (Community and Facility Based Day, and In-home Day)
o Family Model Residential Support (Host Home), only provided in the Comprehensive Waiver
o Individualized Support Living, only provided in the Comprehensive 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 83% of the individuals in these DMH settings will fall under this 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 assumed approximately 17% of the individuals in these DMH 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 140 providers with 152 settings (physical addresses) through DMH will 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 DMH 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/hcbs/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 MHD worked with DMH and the state's Office of Administration beginning October 16, 2014 to develop a Geographic Information System (GIS) report 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 the DMH sites licensed or certified by the department's Licensure and Certification Unit, Department of Health and Senior Services Nursing facilities, public institutions, Residential Care Facilities, Assisted Living Facilities, and DMH providers accredited through Commission on Accreditation of Rehabilitation Facilities (CARF) and deemed certified through DMH. The GIS system was completed by March 30, 2015.
o DMH 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 DMH has identified approximately 140 providers with 152 settings of HCBS heightened scrutiny settings through the GIS mapping. Settings are categorized by the three (3) heightened scrutiny categories below.
1. Zero (0) providers with settings located in or adjacent to a publicly or privately owned- facility that provides inpatient treatment.
2. Eight (8) providers with eight (8) setting locations on the grounds of, or immediately adjacent to, a public institution. Two providers with

two settings provide residential services within 1/8 of a mile of a public nursing home. Six providers with six settings provide residential services on the same grounds or immediately adjacent to state schools for the disabled or blind.
3. One hundred thirty-two (132) providers with 144 setting locations appear to have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.
• Twenty (20) providers with 21 settings providing multiple DMH HCB services in one location (residential & non-residential by the same provider). Individuals in these settings receive residential services while also receiving services such as day services, community integration, and employment services in the same location.
• Five (5) providers with nine (9) settings providing multiple DMH HCB services in one location (residential & residential by the same provider). Individuals in these settings receive residential services in apartments or duplexes.
• Seven (7) providers with 12 settings providing multiple DMH HCB services within 1/8 of a mile (residential & non-residential). Individuals in these settings receive residential services within 1/8 mile of service settings such as day services, community integration, and employment services by the same provider.
• Ninety-six (96) providers with 96 settings providing multiple DMH HCB services within 1/8 of a mile (residential & residential by the same provider). Individuals in these settings receive residential services within 1/8 mile of other individual(s) receiving residential services by the same provider.
• Four (4) providers with six (6) settings providing HCB waiver services within the same building (DMH & Adult Day Care by the same provider). Individuals in these settings are receiving DMH Day Habilitation services within the same building as DHSS Adult Day Care waiver services.
o 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. DMH was required to begin this process on February 1, 2014 and complete it by December 15, 2014.

o The DMH Assessment Tool incorporates CMS Exploratory questions for Residential and Non-Residential Settings (https://www.medicaid.gov/medicaid/hcbs/downloads/exploratory-questions-re-settings-characteristics.pdf and https://www.medicaid.gov/medicaid/hcbs/downloads/exploratory-questions-non-residential.pdf) and Missouri exploratory questions (https://dss.mo.gov/mhd/providers/pdf/missouri-exploratory-questions.pdf) to develop the Initial Setting Assessment Tool. The DMH Assessment Tool may be found at http://dmh.mo.gov/docs/dd/onsiteassessmentinstrument.pdf.
o DMH staff received training on administering the tool prior to conducting on-site reviews.
o The Assessment tool includes residential, provider owned and controlled residential, non-residential, and heightened scrutiny sections that specifically reference the HCBS Setting Rule.

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 DMH identified HCB Waiver service settings through three components. The first component was the identification of providers and settings through the provider self-assessment submitted. In addition to validation of 100% of the provider self-assessments, the second component was the development of a random sample pull of individuals receiving HCB waiver services through the five DMH HCBS waivers. The third component was the identification of DMH HCB Waiver service settings considered heightened scrutiny (qualities of an institution or effect of isolating individuals) through GIS mapping.
o A statistically valid sample size of settings (based on 95% confidence level) was utilized for assessment using the RAOSoft Sample Size Calculator program.
Continued in the Additional Needed Information (Optional).

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Missouri Home and Community-Based Services Settings Rule Statewide Transition Plan March 14, 2015 Amended July 27, 2016 continued.

o This statistically valid sample with the 95% confidence level calculates to approximately 930 on-site assessments out of approximately 2,200 service sites.
o In addition to the random sample pull and GIS identified Heightened Scrutiny settings, individuals and providers requested and still may request DMH to conduct on-site assessments through the participant and provider surveys.
o As a result of the random sample, Heightened Scrutiny, and requested assessments, DMH initiated assessments for 1,044 individuals. This amount could decrease due to individuals no longer receiving services; individuals choosing not to participate in assessments; a provider's terminated contract; death; etc.
o DMH staff conducted on-site, face-to-face assessments with individuals, guardians, and others chosen by the individual utilizing the DMH Assessment Tool (http://dmh.mo.gov/docs/dd/onsiteassessmentinstrument.pdf). The assessment process included review of the Individual Support Plan (ISP); consideration of the individual's perspective of choice, full access to the community, and quality care; observation of the setting; and information from direct care staff, support coordinators, and providers. Individuals were able to decline an assessment, which is

noted on the assessment tool.
o As assessments were completed for individuals served, DMH staff developed a summary of findings for each individual assessed (including requirements for remediation) and distributed the summary to the individual, the service provider, and the support coordinator within 45 calendar days of the completed on-site assessment.
o Settings found to need consideration of a state request to CMS for Heightened Scrutiny were given priority of review by DMH.
o Data collected from the assessments were included in a database to analyze at various levels such as provider, setting type, individual, and region.
o Please see the HCBS Waiver Settings Assessment Findings and Provider Individual Remediation milestones under the Remediation Strategies Section for more details.

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.

Provider Enrollment Process Assessment
MHD required DMH 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 DMH posted information about the Final Rule and setting requirements on its website for all prospective and newly enrolling providers.
o DMH included information about the Final Rule in its Frequently Asked Questions document, distributed to all newly enrolling providers and posted on the DMH website (http://dmh.mo.gov/dd/hcbs.html).
o All newly enrolling HCBS providers go through an application and training process with DMH before enrolling with Medicaid and obtaining a contract with DMH.
o DMH has incorporated the setting requirements into its provider application for HCBS providers. The application includes a section dedicated to educating providers on the HCBS rule and obtaining their commitment to comply with the rule. In addition, waiver providers of Group Home, Individualized Support Living, Shared Living, Day Habilitation, Community Integration, Individualized Skills Development, Employment and Personal Assistant services are evaluated based on responses to questions related to the HCBS rule. All HCBS providers are given information and the self-assessment.
o DMH has incorporated the setting requirements into its newly enrolled HCBS provider pre-training assignment. Waiver providers of Group Home, Individualized Support Living, Shared Living, Day Habilitation, Community Integration, Individualized Skills Development, Employment and Personal Assistant services are required to complete this assignment prior to approval for enrollment with Medicaid and obtaining a contract with DMH.
o DMH has incorporated the setting requirements into its Certification Instrument. Newly enrolling Waiver providers of Group Home, Individualized Support Living, Shared Living, Day Habilitation, Community Integration, Individualized Skills Development, and Employment services must obtain Certification or Accreditation prior to enrollment with Medicaid and obtaining a contract with DMH. Newly enrolling Waiver providers of Personal Assistant must be DHSS providers or must obtain Certification or Accreditation prior to enrollment with Medicaid and obtaining a contract with DMH.

Section 2: 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 and/or 9 CSR 45-5.060.

Informational Letters
MHD required DMH 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 DMH determined that regulations did not contradict the HCBS rule and therefore no regulations were considered to be non-compliant.
o DMH determined that regulations did contain partially compliant provisions concerning individual support plans; however the regulation did not include all components of the person-centered plan and process. DMH revised the regulation by including all the language in the person-centered planning process and person-centered plan sections of the HCBS Rule. Certification of Provider regulations address individuals' needs for privacy, dignity, respect, choice of providers and services, but need to be amended to include requirements for freedom from coercion and restraint
o DMH determined that regulations contain compliant provisions concerning prioritizing access to services, utilization review process, and certification of providers. Sections in the rules include language that the planning process for service delivery is directed by the individual, includes preferences and outcomes desired by the individual, and requirements for community integration to ensure individuals are active in the

community in which they live and work, self-determination, the assurance of rights, and the promotion of individual well-being.
o DMH determined that provider enrollment requirements were silent in state regulation, because there were no specific provider enrollment regulations. Provider Enrollment regulations were drafted and posted for public comment. These regulations include requirements that the provider must sign and agree to be in compliance with the HCBS Settings rule.

Provider Manuals, Policies, and Procedures Revisions
MHD and DMH 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, including revisions to DMH waiver services definitions for Employment services, Day Habilitation, Community Integration, Personal Assistance, Individualized Skill Development to enhance and support integration in the community, began on January 1, 2015 and will be completed by July 1, 2017.

o HCBS Definitions: Proposed changes were included in waiver renewal applications for the Comprehensive and Community Support Waivers. Amendments will be submitted to CMS for the remaining waivers. The following definition changes were submitted to help set expectations to appropriately align incentives toward individual integrated employment and community integration: Day Habilitation, Personal Assistance, Employment Services, Community Integration, and Individualized Skill Development
o Guidelines, manuals, and contracts were partially compliant and are in the process of revision to incorporate all components of the HCBS settings rule. Contracts were revised to add a section that requires the contractor to ensure the delivery of waivered services comports with the Federal Rule 42 CFR441.301 also referenced as the Home and Community-Based Services (HCBS) Waiver Rule.

Incorporate Education and HCBS Waiver Compliance Understanding into Provider Enrollment
MHD requires DMH 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 Department processes are outlined below.
o DMH will make adjustments to ensure that HCBS Waiver settings are evaluated when appropriate–Newly enrolling HCBS providers of Group Home, Individualized Support Living, Shared Living, Day Habilitation, Community Integration, Individualized Skills Development, Employment, Respite, and Personal Assistant services will be provided information on HCBS setting requirements through the application and training process prior to registering with Medicaid or contracting with DMH. DMH will require providers of Group Home, Individualized Support Living, Shared Living, Day Habilitation, Community Integration, Individualized Skills Development, Employment, Respite, and Personal Assistant services to certify that they have received, understand, and intend to comply with these setting requirements.
o Thereafter, ongoing monitoring by division quality integrated functions (to include Provider Relations Reviews and Licensure and Certification Reviews) will be conducted to ensure compliance with the HCBS requirements.

Provider Update Meetings and Trainings
MHD requires DMH 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 quarterly thereafter. The requirements of the Home and Community-Based Federal rule will be incorporated into Provider Enrollment Tools and the Provider Agreements. Specific Department processes are outlined below.

o DMH will provide information regarding the HCBS settings rule and any further guidance from CMS to HCBS providers via webinars and during quarterly provider meetings in each region. Webinars will be posted on the DMH website and providers informed by email when webinars have been posted.
o DMH will provide information and training to self-advocates, families, providers, stakeholders, etc. designed to enhance individualized person-centered planning.
o DMH link to the periodic provider trainings : https://dmh.mo.gov/dd/docs/HCBSDraftTrainingCrosswalkSummaryupdatedJanuary2017.pdf

MHD recognizes that the two Operating Agencies of the State's ten HCBS waivers function in different manners. Therefore, MHD requested each agency to develop assessment and remediation processes unique to their structures and functions. The next section describes the processes by agency.

HCBS Waiver Settings Initial Assessment Findings and Provider Individual Remediation
Upon completion of the initial assessments, DMH presented individuals, service providers and support coordinator entities with the results of the assessment within 45 calendar days of the initial on-site assessment. The initial on-site assessment summary of findings letter required HCBS Waiver service providers and support coordinator entities to submit a single collaborative remediation/transition plan within 45 calendar days from the date of the cover letter and findings report for any areas that required remediation to ensure compliance with the HCBS Settings Rule is achievable by March 2019. Providers and Support Coordinator entities will provide details about the steps to be taken to remediate issues and the expected timelines for compliance.

The remediation/transition plan must include the provider's plan with milestones to ensure compliance with the HCBS Final rule including systemic programmatic changes and assurances of documentation in the person-centered service plans. DMH requests providers to include in

the submission amended or newly created policies, protocols, and procedures concerning the HCBS Setting Rule and to demonstrate how initial and ongoing compliance is ensured concerning the HCBS Settings Rule.

DMH review of remediation plans will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. DMH will review initial and ongoing compliance through providers' proposed system modifications and related changes to ensure compliance concerning the HCBS Setting Rule.

Provider remediation will occur from March 2, 2015 through March 17, 2018.

State Response to Provider Individual Remediation
DMH will accept the remediation/transition plan or may ask for changes to the plan. DMH may prescribe remediation requirements for each organization's HCBS Waiver settings. Changes may include evidence of changes to policies, procedures, manuals, and trainings.

Findings and Remediation Plans will be entered into a DMH tracking system and into the DMH Action Plan Tracking System (APTS) for individual specific remediation. The tracking systems are used by DMH staff to track findings and ensure final remediation in accordance with the HCBS Settings Final rule. APTS tracks findings and ensures final remediation in accordance with quality integrated functions in accordance with division directive 4.080 (http://dmh.mo.gov/docs/dd/directives/4080.pdf) and has been updated to include HCBS federal requirements.

If a provider does not meet the proposed milestones, this will be noted in the tracking system which could lead to placement on a provider improvement plan or a critical status plan (no growth/no referral), or termination of contract as outlined in Division Directive 4.080. (http://dmh.mo.gov/docs/dd/directives/4080.pdf)

DMH will continue to work with providers to ensure compliance with the HCBS Settings rule between March 2, 2015 and March 17, 2018. Individuals in a non-compliant setting as of March 17, 2018 will begin the transition process to a compliant setting. Please see Individuals Transition to Settings that Align with HCBS Requirements section for further details.

Periodic Provider Remediation Status Updates
DMH will require all providers with remediation/transition plans to submit monitoring updates on a quarterly basis. The process for tracking and monitoring provider remediation plans will include monitoring provider transition plans by central office staff based upon milestones submitted and accepted by the department, during routine Provider Relations Reviews, Quality Enhancement Reviews to include National Core Indicator Surveys, TCM Technical Assistance Coordinator Reviews, Service Monitoring by Support Coordinators, and Licensure and Certification Reviews. A tracking spreadsheet that identifies the provider transition plan milestones and deliverable dates will be used to help coordinate this effort. The central office staff will monitor evidence submitted by the providers in relation to their approved milestones. Technical assistance will be provided if there is a problem with the implementation of the remediation plan, if providers are not implementing the plans or if the providers decide to significantly change their plans or the implementation of their plans. 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 process changes. Global systems enhancement might include revisions to existing integrated quality monitoring processes and enhanced HCBS provider and support coordination trainings. This process will occur between March 2, 2015 and March 17, 2018.

Ongoing Compliance/Monitoring Reviews
DMH will conduct ongoing reviews to establish and monitor levels of compliance. DMH will incorporate requirements of the HCBS Setting Rule into existing review processes and quality integrated functions: Provider Relations Reviews: Quality Enhancement Reviews including National Core Indicators; Targeted Case Management Technical Assistance Coordinator Reviews; Service Monitoring by Support Coordinators; Licensure and Certification Reviews; and the CIMOR EMT Contacts Process which includes anonymous input from individuals served and their advocates. The quarterly/annual monitoring processes include on-site, face to face assessments of providers with waiver participants.

• Provider Relations Reviews Guideline prescribes the functions of Provider Relations and incorporates monitoring for ongoing compliance of provider systems (http://dmh.mo.gov/dd/guidelines.html). This guideline has been updated to include monitoring compliance with the HCBS Settings Final rule. For example, it was updated to include a new component, "Lease HCBS," which incorporates the lease requirements for provider-owned and controlled settings; and a new component, "Policies & Procedures support the HCBS Rule," incorporates individual choice requirements in the HCBS Settings Final rule.

• Quality Enhancement Reviews to include NCI Surveys - The Quality of Services Review (QSR), which includes the National Core Indicator (NCI) survey as part of the review process and incorporates the Missouri Quality Outcomes, prescribes a standardized procedure to evaluate if individuals have full access to the benefits of community living and the opportunity to receive services in the most appropriate integrated setting, assess the person-centered planning process and provide feedback to the interdisciplinary team about utilizing key points of self-determination(Appendix B-Quality of Services Review Summary Word Document):
o Individuals will live a meaningful life in the community and be empowered in making life decisions.
o Individuals will have support to organize resources in ways that are life enhancing and assist them in reaching their dreams and goals. Individuals have a circle of supports made up of family, friends, and both paid and unpaid supports.

o Individuals assume responsibility for giving back to their community, for seeking employment, and for developing unique gifts and talents.
o Individuals are recognized for who they are and what they can contribute.
o Enhancing identified areas (values, choice, health, safety, inclusion, and self-advocacy).
o Individuals are able to choose health and mental health resources and are supported in making informed decisions regarding their health and well-being.
o Individuals are educated about their rights and practice strategies to promote their safety and security.
o Families are provided with knowledge that empowers them to facilitate opportunities for the individual's self-determination throughout the course of the individual's life.

The Quality of Services Review (QSR) is conducted with a statistically valid sample of individuals in the comprehensive waiver. Primarily, these individuals reside in residential settings but a marginal number of individuals reside in natural homes. Since this review process was implemented in FY16 and specifically based on the new HCBS rule, it is compliant with the quality required by regulation.

Reference:
Guideline #54 Quality of Services Review (created 7/8/15 from Division Directive 3.100)PDF Document
http://dmh.mo.gov/dd/guidelines.html
o Appendix A-Quality of Services Review Supplemental Guide Word Document
o Appendix B-Quality of Services Review Summary Word Document
• TCM Technical Assistance Coordinator Reviews is outlined in Guideline #9, Guidelines for Targeted Case Management Review. This guideline covers areas reviewed based on CMS assurances. The review tool was revised on July 1, 2015 to include person-centered planning requirements as required in the final HCBS rule. http://dmh.mo.gov/dd/guidelines.html
• Service Monitoring by Support Coordinators, Division Directive 3.020, was revised on September 23, 2015 to incorporate requirements in the final HCBS rule and was posted by April 2, 2016. The purpose of this directive is to prescribe the support monitoring standards. Support Coordinator training for the final HCBS rule and person centered planning guidelines occurred in January and July 2015. This was in advance of the revised ISP Guide which will incorporate requirements of HCBS rule based on stakeholder input and remediation.
• Licensure and Certification Reviews were evaluated and determined to be in partial compliance with the HCBS rule. The Survey Instrument used for the reviews includes all components of the rule such as rights of privacy, dignity, respect, freedom for coercion, and individual choice. The instrument will be revised to include HCBS requirements regarding setting integration and individuals receiving services in the community.
• Review of ISP Guidelines: Individuals are provided information on rights upon entry to the waiver and annually during the individual support planning process. The support coordinator will provide a rights brochure, developed by the division, to the individual and guardian. In addition, information is posted on the division's web-site:
o The DMH Consumer Rights brochure does not have specific language to comply with the final HCBS federal rule for anonymity. After reviewing the DMH Consumer Rights brochure, the Department will include the DMH website URL on the brochure and a statement in regards to the ability to make anonymous reports to Office of Constituent Services (OCS).
o The Division Individual Rights document does not have specific language to comply with the final HCBS federal rule for anonymity. After reviewing the rights brochure developed by the division will include a statement in regards to the ability for individuals to make anonymous reports to OCS.

• Review of Missouri DMH-Office of Constituent Service website (http://dmh.mo.gov/constituentservices/index.html). The DMH Client Rights brochure and other information regarding consumer rights and abuse/neglect is posted on this web site. The site also has a consumer safety video which discusses abuse and neglect and the reporting and investigation process, as well as the brochure Keeping Mental Health Services Safe which is a written version of the video. In the Frequently Asked Questions section on the website it does state and answer the question: What should I do if I suspect that a mental health client or family member may have been the victim of abuse or neglect? You may call the toll free number at 1-800-364-9687 and ask for the Office of Constituent Services. The office encourages everyone to make the contact for the safety of all clients. All calls will be kept confidential and the caller can choose to remain anonymous.
o Review of Comprehensive Waiver Application states that the Division of DD Consolidated Contract requires that each provider give participants the name, address, and phone number to the DMH Office of Constituent Services. Each consumer is informed that they have the right to contact this office with any complaints of abuse, neglect, or violation of rights.
o Review of the contract did not reflect this requirement. It is recommended that this statement be added to the contract to include the statement that an anonymous complaint can be made to the Office of Constituent Services.
• Review of the ISP Guide –The purpose of the ISP Guide is to ensure that the Person Centered Planning Process and resulting document meet the assessed needs of the individual and the regulatory requirements. In order to be compliant with the final HCBS rule the following requirements were added:
o individual directs the person centered planning process;
o individual understands methods for requesting changes;
o plans are not written by direct service providers;
o plans are written in plain language;
o plans include conflict resolution;
o plans include anonymous complaint information;
o plans include documentation of supports and setting options explored; and
o plan ensures needs are assessed, preferences are determined and risk factors minimized in the area of: Daily Life and Employment; Community Living; Social and Spirituality; Healthy Living; Safety & Security; Citizenship and Advocacy.
The ISP Guide was also updated to ensure that all required documentation is included in the plan if there are any modifications to provider owned or controlled residential settings and those modifications are supported by a specific assessed need and justified in the ISP.

This milestone will begin April 2, 2015 and will continue on-going.

Provider Sanctions
In accordance with 13 CSR 70-3.030 and/or 9 CSR 45-5.060, DMH will sanction providers that have failed to meet remediation standards and have failed to cooperate with the HCBS Settings Transition. This milestone will begin February 3, 2015 and continue on an ongoing individual provider basis.

Individuals Transition to Settings that Align with HCBS Requirements
If relocation of individuals is necessary, the State will work with the individuals to ensure they are transitioned to settings meeting HCBS Setting requirements following Division Directive 5.010. The purpose of the directive is to implement a consistent, State-wide process for transfer of individuals, ensuring a smooth transfer that maintains services, with no delay in obtaining new supports and services. Individuals will be given timely notice and due process, 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. The division is in the process of developing a Transition manual which will incorporate Division Directive 5.010 at which time the Division Directive will be rescinded. (http://dmh.mo.gov/dd/directives/directives.html). DMH estimates that less than 100 individuals will need to relocate.

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

DMH will utilize the Sanction Template Letter including the Notice of Decision (including appeal rights) and the Data warehouse query of members affected and corresponding support coordinators, service workers, and care coordinators.

Section 3: 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. The State received comments from stakeholders through a series of stakeholder forums conducted throughout the state. In addition to posting the transition plan and related materials on the MO HealthNet website, numerous stakeholders were contacted directly and provided with transition plan documents and information on the stakeholder forums. Stakeholders contacted include Missouri Association of County Developmental Disabilities Services (MACDDS), Missouri Association of Rehabilitation Facilities (MARF), Developmental Disabilities (DD) Council, People First, and The Arc. The State and the DD Council will continue to explore opportunities to ensure that individuals and families receive and understand information regarding the HCBS rule, and that they are a part of system changes.

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 commenced stakeholder forums, 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.

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 Mental Health, Division of Developmental Disabilities

   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 Missouri Department of Social Services, MO HealthNet Division (MHD) has developed a HCBS waiver quality management strategy that is used to ensure that the operating agency, the Division of Developmental Disabilities (DD), is performing its assigned waiver operational functions and administrative functions in accordance with the waiver requirements during the period that the waiver is in effect. MHD and Division of DD meet quarterly to discuss administrative/operational components of the Missouri Children with Developmental Disabilities Waiver. This time is also used to discuss the quality assurances as outlined in Appendix H. Through a MOU that exists between the two (2) agencies, communication remains open and additional discussions occur on an as needed basis.
Quarterly and annually MHD conducts an analysis of quarterly and annual reports submitted by Division of DD to ensure that the operational functions as outlined in A-7 are being implemented in a quality manner. MHD reviews the information to ensure the following assurances are meeting the established outcomes: 1) Level of Care (LOC), 2) Plan of Care, 3) Qualified Providers, 4) Health and Welfare, 5) Administrative Authority, and 6) Financial Accountability. A formal report is provided to Division of DD outlining the results of the analysis and listing any areas for improvement. Division of DD in turn provides a written corrective action plan for any areas of deficiency, outlining the steps to be taken to ensure the assurances are being met. Goals and timelines are included. MHD works closely with Division of DD to monitor areas of deficiencies, to set goals and establish timeframes for compliance.

In addition to Division of DD ongoing record reviews throughout the year, MHD performs a statistically valid, statewide, annual record review, targeting problem areas identified through the reporting listed above. Problem areas are discussed with DMH Division of DD who provides a corrective action plan to MHD outlining the steps being taken to address the problem. MHD continues to monitor for compliance to ensure that the action steps have been taken in a timely manner.

The MHD monitors that DMH Division of DD is providing oversight for disseminating information concerning the waiver to potential enrollees, assisting individuals in waiver enrollment, and conducting level of care evaluation activities through the quarterly meetings, review of statistical reports and the annual record review.

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.:*
   Division of DD has a statewide contract for Fiscal Management Services that provide administrative functions to support individuals who self-direct services. This is the only contract entity that provides administrative services to waiver participants. The contractor's responsibilities are specifically related to processing payroll and reporting and paying related taxes and is not responsible for any functions listed in A-7.

   ( ) **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:

   [x] **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 non-state entities (counties), referred to as Missouri County SB-40 Boards that are approved to provide TCM for persons who have Developmental Disabilities, perform waiver operational and administrative functions at the local level with oversight from the operating agency, Division of DD. There is a contract between the Division of DD and these entities that sets out the responsibilities and performance requirements. The contract between the State operating agency and these entities is available through the MHD, the Medicaid agency. Participation in administrative/operational functions include: Participant waiver enrollment; waiver enrollment managed against approved limits; level of care evaluation; review of participants'

service plans; utilization management; quality assurance and quality improvement activities.

The delegated functions are based on regional availability. The Division of DD designates local non- state entities and local non-governmental, non-state entities and maintains an active case management agreement or inter-governmental agreement with the Division of DD.

☑ **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:

Local non-governmental non-state entities, referred to as other not for profit entities that contract with the Division of DD to provide TCM services perform waiver operational and administrative functions at the local level with oversight from the operating agency, Division of DD. There is a contract between the State and these entities that sets out the responsibilities and performance requirements for these entities. The MOU between the State operating agency and these entities is available through the MHD, the Medicaid agency. Participation in administrative/operational functions include: Participant waiver enrollment; waiver enrollment managed against approved limits; level of care evaluation; review of participants' service plans; utilization management; quality assurance and quality improvement activities.

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:
The Operating Agency, Division of DD, is responsible for assessing the performance of entities approved as TCM providers for persons who have developmental disabilities and that also have responsibility for limited waiver administrative functions. In addition, the sample records of waiver participants that the MHD reviews, includes records of individuals for whom SB-40 County Boards provide administrative functions.

   Division of DD is also responsible for monitoring the fiscal management services (FMS) contractor to ensure participants are promptly enrolled, workers are accurately paid, and associated payroll taxes for the employers are deposited.

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:
1) Support coordinators employed by regional offices and other approved TCM entities conduct the initial and annual level of care evaluation. The Division of DD Regional Offices provides final approval of eligibility decisions, all support plans, and prior authorizations.
Each Regional Office has a Utilization Review Committee that meets at least monthly. The committees review all new service plans and budgets and also any support plans and associated budget when an increase in spending is requested. All decisions are subject to the approval of the MHD.
2) Division of DD Regional Office Technical Assistance Coordinators (TAC) conducts quarterly reviews with TCM entities (both local public entities and local non-public entities) that have been delegated waiver administrative functions in the following areas:
a. Participant waiver enrollment
   Qualifications of staff;
   Evidence the annual support plan was prepared according to guidelines;
   Evidence due process and appeals processes are followed;
   Accuracy of information entered in the Division's Consumer Information Management system;
   Evidence records are maintained for each consumer receiving support coordination; and
   Evidence participant was provided choice of waiver service or ICF-ID service.
b. Participant waiver enrollment managed against approved limits
c. Level of care evaluation
   Qualifications of staff;
   Evidence the ICF/ID Level of Care evaluation was completed following the procedures;
   Evidence the participant was accurately found eligible or ineligible; and
   Evidence participants were reevaluated annually by qualified staff, who
   followed the process; and
   Evidence determinations were accurate
d. Review of participant support plans

e. Utilization management
Support plan supports waiver services that are prior authorized;
Support coordinator case notes indicate monitoring was conducted of participants to prevent occurrences of abuse, neglect, and exploitation using risk assessment & planning;
Service authorizations accurately reflect budget and support plan;
Support plans are updated/reviewed at least annually or when warranted by changes in the participant's needs;
Evidence that provider monthly reviews were done and documented in log notes;
Evidence that quarterly reviews were prepared;
Evidence services were delivered in accordance with the support plan including the type, scope, amount, duration, and frequency as specified in the plan.
f. Quality assurance and quality improvement activities
3) Annually, the MHD reviews case records for a randomly selected group of waiver participants. This is a comprehensive compliance review of all waiver administrative responsibilities. All determinations and decisions by Division of DD and county entities in operating the waiver are subject to approval of the MHD.

MHD at any time can choose to review and approve/deny any of the items identified in this section. Per 3) annually MHD reviews case records. In addition, MHD conducts an analysis of all quarterly and annual reports.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

contracted entities.

i. **Performance Measures**

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of waiver policies/procedures approved by the Medicaid agency prior to implementation. (Number of waiver policies/procedures reviewed prior to implementation / total number of waiver policies/procedures that were reviewed)

Data Source (Select one):
Program logs
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:
 # & % of determinations of level of care (LOC) where the proper forms were not used that were properly remediated by Division of DD (DD). (# of determinations of LOC where the proper forms were not used that were identified in the record review that were properly remediated by DD/# of determinations of LOC where the proper forms were not used that were identified in the MO HealthNet record review)

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-.5%
☐ **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 untimely reevaluations of level of care determinations that were properly remediated by Division of DD. (Number of untimely reevaluations of level of care determinations identified in the record review that were properly remediated by Division of DD /number of untimely reevaluations of level of care determinations identified in the MO HealthNet record review.)

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-.5%
☐ **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:
 # & % of service plans that DD properly remediated that had a finding that the plan was not adequate or appropriate to meet the needs in the plan.(# of service plans with findings that the plan was not adequate or appropriate to meet the participant's needs that were properly remediated/# of service plans with findings that the plan was not adequate or appropriate to meet the participant's needs)

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-.5%
☐ **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 MO HealthNet remediation actions requested of Division of DD, by type of remediation, that were properly resolved by Division of DD. (Total number of remediation actions properly resolved, by type of remediation/total number of remediation actions requested, by type of remediation)

Data Source (Select one):
Program logs
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:
 # & % of redeterminations of level of care (LOC) made by persons other than a qualified staff that were properly remediated by Div. of DD. (# of redeterminations of LOC made by persons other than a qualified staff identified in the record review that were properly remediated by Div. of DD/# of redeterminations of LOC made by persons other than a qualified staff in the MO HealthNet record review.)

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☐ **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 untimely initial level of care determinations that were properly remediated by Division of DD. (Number of untimely initial level of care determinations identified in the record review that were properly remediated by Division of DD/number of untimely level of care determinations identified in the MO HealthNet record review.)

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver enrollment complaints received by MO HealthNet that were resolved by Division of DD within timeline requested. (Number of enrollment complaints received directly by MO HealthNet that were resolved timely by Division of DD/total number of enrollment complaints received directly by MO HealthNet)

Data Source (Select one):
Program logs
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.

The MHD has a MOU with the Division of DD delegating administrative duties. The MHD receives quarterly reports from the Division of DD in advance of a quarterly meeting with administrative and quality enhancement leadership team of Division of DD. Findings in the report are discussed and trends noted. The MHD requests additional information and corrective action based on a review of data reported and discussed. Meeting minutes record discussions and follow-up/remediation required of Division of DD by the MHD. The MHD also has samples individual remediations reported by the Division of DD to ensure findings were properly resolved around level of care, service plan, health and safety, and qualified provider.

Performance measures related to policy and procedure review: A review of waiver policies and procedures will ensure that no waiver policy/procedure is implemented by Division of DD prior to approval by the MHD. These reviews will be documented in the MHD Waiver Review Log.

In addition, the MHD will, through ongoing review of service plans, utilization review/quality review processes provided by Division of DD, and data obtained through the MMIS monitor to ensure compliance with all assurances and sub-assurances. If the MHD discovers that a policy/procedure was implemented by Division of DD without the MHD's approval, the MHD will immediately notify Division of DD in writing that such policy or policy modification is not effective pending the review and approval of the MHD. The MHD will perform an expedited review of the applicable policy or policy modification, and will provide a written response regarding the disposition of the policy or policy modification. If revisions to the policy are needed, the MHD will advise the Division of DD regarding required revisions, with subsequent review and approval by the MHD prior to implementation of the policy or policy modification. If approved, the effective date of such policy or policy modification will be no earlier than the date of approval by the MHD.

Remaining performance measures: Issues which require individual remediation may come to the MHD's attention through quarterly review of the Division of DD Quality Management Reports, as well as through day-to-day activities of the MHD, e.g., review/approval of provider agreements, utilization review and Quality Review processes, complaints from MHD participants related to waiver participation/operation by phone or letter, etc. Remediation activities will be reported to the MHD by the Division of DD as follow-up to these activities, and will also be aggregated in the Division of DD Quality Management Reports.

The MHD requires that all individual issues are appropriately and timely remediated by Division of DD. If the MHD discovers that any issue was not appropriately remediated, the MHD will notify Division of DD and provide 10 days to identify an effective remediation strategy and 30 days to provide documentation to the MHD that the strategy was implemented and was effective. All such issues will be included on the agenda for discussion at quarterly Quality Management Strategy Meetings. Inadequate remediation strategies identified by the MHD, as well as alternative remediation strategies implemented by the Division of DD and dates of completion will be included in the MHD Waiver Review Log. The Waiver Review Log will identify the MHD findings related to each performance measure, the MHD and/or Division of DD remediation actions as appropriate, and timeframes required for remediation. On a quarterly basis, the MHD Waiver Review Log will include an analysis of data received from the Division of DD and data generated by the MHD for the purpose of identifying the number and percentage of MHD and Division of DD findings appropriately remediated in accordance with specified timeframes.

ii. Remediation Data Aggregation

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

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

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

- (●) **No**
- ( ) **Yes**
  Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
[ ] Aged or Disabled, or Both - General					
	[ ]	Aged			[ ]
	[ ]	Disabled (Physical)			
	[ ]	Disabled (Other)			
[ ] Aged or Disabled, or Both - Specific Recognized Subgroups					
	[ ]	Brain Injury			[ ]
	[ ]	HIV/AIDS			[ ]
	[ ]	Medically Fragile			[ ]
	[ ]	Technology Dependent			[ ]
[x] Intellectual Disability or Developmental Disability, or Both					
	[ ]	Autism			[ ]
	[x]	Developmental Disability	0	17	[ ]
	[x]	Intellectual Disability	0	17	[ ]
[ ] Mental Illness					
	[ ]	Mental Illness			[ ]
	[ ]	Serious Emotional Disturbance			

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

The child must be living at home and not in a group home residential placement or in custody of the state. The child must be under the age of 18.

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:

Prior to the individual's 18th birthday, the needs of the participant and how best to meet the needs will be reassessed. All potential means of continuing to meet the participant's needs will be considered including, but not limited to: access to private insurance, State plan services, local programs, other state programs, and enrollment in another DD HCBS waiver for which the individual is eligible.

Participants have priority consideration as they age out and there is reserve capacity in the other waivers.

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)

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:

In advance of enrollment in the waiver, the needs of the individual and how best to meet the needs are identified. From this assessment, a support plan is developed that specifies the amount, frequency, and duration of all services that are needed to assure health and safety. All potential sources for meeting the needs will be explored such as private insurance, other federal programs, state and local programs as well as non-paid support provided by family and friends. The total cost of needed services through the waiver will be compared to the average cost of ICF/ID care.

If enrollment in the waiver is denied the applicant is notified writing that they have an opportunity to request a fair hearing.

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:

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

  Specify:

  Participants in this waiver are not eligible for MO HealthNet due to parental income and resources without access to the waiver. Therefore, they will not be eligible for another waiver. Other safeguards: 1) Most have private insurance and are encouraged to keep their private insurance coverage. Children whose parents have or have access to private insurance are encouraged to apply for the DSS Health Insurance Premium Payment Program; and 2) participants are children under the age of 18 whose family members usually assist with some of the care without compensation. If an individual cap was met and additional services were needed, the Regional Office may consider using State funds to meet the additional need, may refer the family to a local County SB-40 Board for funds to meet the additional need, and may refer the individual to other services in the community.

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	366
Year 2	366
Year 3	366
Year 4	366
Year 5	366

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	350
Year 2	350
Year 3	350
Year 4	350
Year 5	350

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).**

Purpose(s) the State reserves capacity for:

Purposes	
Emergency/Crisis Status Determined by Utilization Review	

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Emergency/Crisis Status Determined by Utilization Review

Purpose *(describe):*

Assure individuals on waiting lists with greatest needs are given priority consideration for participation when openings occur. The prioritization of need process assesses the child's unmet needs and assigns points on a scale of 0-12. Twelve (12) representing individuals who have the greatest need in the state. Individuals with scores of 12 are served first state wide before individuals with scores of 11, 10, etc.

Describe how the amount of reserved capacity was determined:

Based on experience in operating the waiver the average annual turnover is 16.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	16
Year 2	16
Year 3	16
Year 4	16
Year 5	16

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:

Division of DD's Utilization Review (UR) Process, conducted by regional offices, prioritizes the needs of individuals in order to identify and serve individuals with the greatest needs first. The UR process is applied to all new support plans and new/increased budgets developed by planning teams. The UR process is standardized for use at all regional offices. Support plans and budgets developed by TCM Entities are also subject to this review process. The process rates priority of need and assigns points with a score of 12 representing individuals who have the greatest need in the State. Individuals with scores of 12 are served first statewide before individuals with scores of 11, 10, etc. are served. Should there be any change in the person's status during this time, the UR Process will be updated in order to reflect the individual's current needs.

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

  Specify:

  See below, special home and community-based waiver group under 42 CFR 435.217.

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: [1285]

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

Select one:

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

Specify percentage amount: [ ]

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

Specify:

The State is not adding any additional eligibility groups. Only the special home and community-based waiver group under 42 CFR 432.217 in a special income level equal to $1,285 as of 1/1/17. For each calendar year for the remainder of this waiver period, the special income level will be adjusted on January 1 by a percentage equal to any Social Security COLA in effect for that year.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

  (*select one*):

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

    Specify:

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

    (*select one*):

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

      Specify percentage: [ ]
    - ○ **A dollar amount which is less than 300%.**

Specify dollar amount:

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

  Specify percentage:

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

  Specify:

- **The following dollar amount**

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

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

  Specify:

- **Other**

  Specify:

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

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

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

  Specify:

  The Federal Benefit Rate

- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

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

- **The amount is determined using the following formula:**

  Specify:

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

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

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard

established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ○ **The amount is determined using the following formula:**

  Specify:

- ○ **Other**
  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

  (*select one*):

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

    Specify:

    [ ]

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

    (*select one*):

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

      Specify percentage: [ ]

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

      Specify dollar amount: [ ]

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

    Specify percentage: [ ]

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

    Specify:

    [ ]

- **The following dollar amount**

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

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

  Specify:

  [ ]

- [x] **Other**

Specify:

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

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

- [x] **Not Applicable (see instructions)**
- [ ] **The following standard under 42 CFR §435.121**

Specify:

- [ ] **Optional State supplement standard**
- [ ] **Medically needy income standard**
- [ ] **The following dollar amount:**

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

- [ ] **The amount is determined using the following formula:**

Specify:

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

- [ ] **Not Applicable (see instructions)**
- [x] **AFDC need standard**
- [ ] **Medically needy income standard**
- [ ] **The following dollar amount:**

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

- [ ] **The amount is determined using the following formula:**

Specify:

- [ ] **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **The following dollar amount:**

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

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

Specify formula:

- ◉ **Other**

Specify:

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

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

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

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

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

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

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By an entity under contract with the Medicaid agency.**

Specify the entity:

The State Plan was amended in 2009 to add a fourth type of TCM provider: not for profit agency registered with Secretary of State and designated by the Division of DD. The Division of DD Regional Office has final approval of all Level of Care evaluations.

Initial evaluations and reevaluations are conducted by a qualified support coordinator employed by the Division of DD or TCM Entities approved by the Division of DD to provide TCM. Initial evaluations and reevaluations level of care determinations are approved by the Division of DD RO's and are subject to the approval of the State Medicaid Agency.

- ○ **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:

Initial evaluations are conducted by a qualified Support coordinator employed by the Division of DD or TCM Entities approved by Division of DD to provide TCM. All LOC determinations are approved by the Division of DD Regional Offices and are subject to the approval of the State Medicaid Agency.
Qualifications of individuals performing LOC evaluations are specified in the Medicaid state plan for TCM for persons with developmental disabilities approved by CMS September 11, 2009. This states that case managers employed by a qualified provider shall meet the minimum experience and training qualifications for a Developmental Disability Professional (DDP). The qualifications for a DDP are the same as the minimum required for the position of Case Manager I with the Division of DD and require:
(1) One or more years of professional experience: (a) as a Registered Nurse (RN); (b) in social work, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy, or a closely related area; or (c) in providing direct care to persons who have developmental disabilities; and
(2) A bachelor's degree from an accredited college or university with a minimum of 24 semester hours or 36 quarter hours of credit in one or a combination of human service field specialties. Additional experience as a RN may substitute on a year-for-year basis for a maximum of two years of required education.

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.

The tool used to evaluate and reevaluate LOC is "Evaluation of Need for an ICF/DD Level of Care and Eligibility for the DD Waiver." An assessment of the individual is conducted before the form is completed using the Missouri Critical Adaptive Behaviors Inventory (MOCABI). This is a tool specific to Missouri that identifies functional limitations and needs. The Vineland Adaptive Behavior Scale or other age appropriate tools may be used for children when more appropriate.

The Division of DD Waiver ICF/ID LOC Determination must confirm and document the following:
1) The person has an intellectual disability or a related condition;
2) The person has a need for a continuous active treatment program, including aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed toward the improvement of functional abilities, or are necessary to avoid regression or loss of current optimal functioning status; and
3) there is a reasonable indication, based on observation and assessment of the person's physical, mental and environmental condition, that the only alternative services that can meet the individual's needs, if waiver services are not available, are services through an ICF/ID.

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 Division of DD.

Evaluations of LOC are completed by qualified support coordinators employed by the Regional Office or an entity enrolled with the MHD to provide TCM for individuals who have developmental disabilities. Regional Office administrative staff review the evaluation of LOC, the draft support plan, the priority of need recommendation and determine final eligibility for the waiver. All LOC redeterminations are approved by the Division of DD Regional Offices and are subject to the approval of the State Medicaid Agency.

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 state uses the same tool to determine eligibility for the ICF/ID services and eligibility for nursing home services. Therefore, a different process/tool is used to determine waiver eligibility. The process/tool is analogous to the initial LOC assessment performed for admission to the ICF/ID and nursing home programs, but is more appropriate to the assessment of persons with developmental disabilities.

The tool walks the evaluator through the process of determining:

1) if the individual has intellectual disability or a related condition based on identifying substantial functional limitations in 3 or more major life activities;

2) if the individual needs a continuous active treatment program, including aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed towards the acquisition of the behaviors necessary to function with as much self-determination and independence as possible; and the prevention of regression or loss of current optimal functional status; and

3) if there is reasonable indication that without access to waiver services the only alternative services that will be available to meet the person's need are ICF/ID services.

The Division of DD Waiver ICF/ID LOC Determination Form is used to determine eligibility. The MOCABI or an age appropriate tool such as the Vineland is administered first to assess functioning level. The evaluator is also asked to report a summary/list of any other assessments and evaluations from the individual's record that may have been considered. Information from these assessments is used to complete the actual LOC determination form which results in a determination of eligibility.

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:

Qualified Support Coordinators reevaluate each participant annually to determine if the individual continues to be eligible for Waiver. The same tool is used in the reevaluations process as is used in the initial eligibility process. The reevaluation includes the reviewing and/or updating previous assessments on which the previous evaluation was based, including the Vineland and re-documentation of conditions of eligibility as listed above.

The following is included in the instructions of the "Evaluation of Need for an ICF/DD Level of Care and Eligibility for the DD Waiver": The MOCABI is the standard, baseline assessment for all waiver participants, except for children under age 18. There may be circumstances where the MOCABI may be appropriate for children age 17. The Vineland or other formal assessments, including psychological or psychiatric assessments, are used for children. In addition, educational and medical records, etc. may be used to assist in documenting the individual's diagnosis and level of functioning.

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

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

  Specify the other schedule:

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

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

  Specify the qualifications:

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

Support Coordinators employed by Division of DD Regional Offices or TCM Entities are responsible for reevaluating each participant as part of the annual person centered planning process regarding the in individual's need for an ICF/ID LOC. Division of DD regional offices must approve claims of eligibility and associated documentation made by TCM entity employees. All decisions are subject to approval of the Medicaid Agency.
The Division of DD Regional Office, in conjunction with the TCM entity providing support coordination, is responsible for ensuring that reevaluations are completed annually. The number of annual re-determinations conducted of all current waiver participants and the number of individuals who continue to be found eligible and the number found to be ineligible are tracked electronically. On a quarterly basis, the Quality Enhancement Leadership Team pulls data to assure compliance with this process as well as implement any necessary corrective action. In addition, Regional Office staff as well as TCM entity staff have direct access to reports to monitor when LOC determinations and formal assessments are coming due. Support Coordinators and Support Coordinator Supervisors receive automated emails as a reminder of upcoming LOC determinations and formal assessments coming due. Support Coordinators enter evaluations electronically. All support coordinators and supervisors have access to centralized data systems in order to verify evaluations are conducted timely.

Quality Management Reports submitted to the MHD by the operating agency and annual sample reviews conducted by the MHD also

ensures that a system has been designed and implemented for assuring reevaluations of the LOC need are conducted in a timely manner.

The DMH Consumer Information Management Outcomes and Reporting system (CIMOR) is a comprehensive data base that contains consumer demographics, service coordination information, waiver assignment, dates of evaluations, service plans, provider demographics, services by provider, waiver service authorizations and other information. CIMOR also has sophisticated reporting capacity, which is the process used to assure timely evaluations.

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:

Evaluation and reevaluation records are located electronically by the Division of DD in the department's CIMOR system.

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:
Applicants to the waiver will have a completed evaluation. (Total number of individuals requesting a waiver slot within the identified time period with a completed evaluation divided by Total number of individuals requesting a waiver slot within the identified time period)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of annual level of care redeterminations completed by the next annual LOC redetermination date. (Number of annual level of care redeterminations that were completed by the next annual LOC redetermination date divided by the Total number of level of care redeterminations completed.)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 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 LOC determinations completed by a qualified staff person. (LOC determinations completed by a qualified staff person divided by Total number of completed LOC determinations)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of LOC determinations using instruments and processes described in the waiver application. (LOC determinations using instruments and processes described in the waiver application divided by Total Number of completed LOC determinations)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of LOC determinations completed accurately. (LOC determinations

completed accurately divided by Total number of completed LOC determinations)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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.

When an error is discovered, a quality enhancement staff notifies the designated regional office staff in writing within 10 days of the date of discovery. The designated Regional Office staff reviews the error, and works with support coordination staff to correct the error. The designated regional office staff enters the issue and remediation into the Division's electronic system within thirty (30) days describing how the error was corrected and any remedial staff training that was necessary. Methods of remediation include: performing a LOC for those that were not done, re-training of staff to perform a LOC accurately, establishing an individual tracking mechanism if one was not in place at the regional/county level. Remediation reported as: completed within 30 days, 31 to 60 days, more than 61 days and not completed.

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Support Coordinator's employed by Division of DD Regional Offices and TCM Entities approved to provide case management explain

to individuals the choice between ICF/ID institutional services and Home and Community Based services. Support coordinators educate individuals/guardians regarding all waiver services and providers available. This will be completed by the support coordinator reviewing options with the individuals/guardians, then the individuals may meet with providers to make their selection.

Individuals, or a legally responsible party, are asked to make a choice between receiving services through the ICF/ID Program or the HCBS Waiver Program. This is documented by the individual or a legal representative signing and dating a Waiver Choice Form. The support coordinator also signs and dates the Waiver Choice form. Prior to authorization of waiver services the individual completes a form giving them the choice between ICF/ID services and waiver services. If they choose the latter only then will waiver services begin. Forms are available upon request from the operating agency.

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.

Signed and dated Waiver Choice Forms are maintained in the individual's record at the regional office or the office of the TCM entity that provides targeted case management.

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):
The state of Missouri maintains a statewide services contract for procurement of in-person spoken language interpretation and a statewide services contract for written language translation. These contracts are available to all State-operated agencies. As a secondary option, the Department of Mental Health maintains a contract for telephone interpretation for situations in which an in-person interpreter cannot be obtained in a timely manner. Foreign language interpretation includes interpretation in over 240 languages. Additionally, all providers of services under contract with the Department are contractually obligated to comply with the Civil Rights Act, and the Department requires that contractors take reasonable steps to ensure meaningful access to services for limited English proficient persons. If a client requests that a volunteer, friend, family member, etc. provide interpretation services, the state agency or contracted service provider may utilize the volunteer, friend, family member, etc. to provide interpretation services, as long as reasonable steps have been taken to ensure the use of a non-professional interpreter is appropriate in the circumstances. In addition, interpreting is an available service in the Division of DD service catalog, and contracted providers are permitted to bill the cost of interpreting services for person-centered planning meetings to the Division of DD. Interpreting capabilities include, but are not limited to, interpreting medical concepts/language, medical brochures, mental health therapy, mental health testing and evaluation, mental health topics in therapeutic situations, legal topics/concepts that focus on a client's incarcerations, capacity, etc., and highly technical concepts such as data processing terms. Interpreters who have completed the Department's Introduction to Mental Health Interpreting course receive preferential hiring for assignments at Department-operated facilities and at contracted service providers.

The State Medicaid Agency (MO HealthNet) operates several informational hotlines. One is the MO HealthNet Participant Services hotline. This is available for MO HealthNet participants who have questions related to their eligibility, covered services, etc. If an individual with limited English proficiency calls, interpreting services are made available.

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	**Day Habilitation**		
Statutory Service	**In Home Respite**		
Statutory Service	**Personal Assistant**		
Supports for Participant Direction	**Support Broker**		
Other Service	**Applied Behavior Analysis**		
Other Service	**Assistive Technology**		
Other Service	**Community Integration**		
Other Service	**Community Specialist**		
Other Service	**Crisis Intervention**		
Other Service	**Environmental Accessibility Adaptations-Home/Vehicle Modification**		
Other Service	**Individualized Skill Development**		

Other Service	**Out of Home Respite**
Other Service	**Person Centered Strategies Consultation**
Other Service	**Specialized Medical Equipment and Supplies (Adaptive Equipment)**
Other Service	**Transportation**

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:

Day Habilitation

Alternate Service Title (if any):

Day Habilitation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Day Habilitation services focuses on fundamental skill acquisition/development, retention/maintenance to assist the individual in achieving maximum self-sufficiency. Day Habilitation Services assists the individual to acquire, improve and retain the self-help, socialization and adaptive skills necessary to reside successfully community. Fundamental skills are a foundation for further learning, such as etiquette in a public setting, recognition of money, proper clothing attire for the time and setting, answering phone, etc. Examples of Day Habilitation Services include, but are not limited to, utilizing etiquette skills at a restaurant, checking out a book at a library, mailing a letter, exchanging money for purchases, etc. This should not only occur in the facility, but on a regular basis in the community to use in a real life situations. Day Habilitation Services differs from the Personal Assistant service in that a personal assistant may directly perform activities or may support the individual to learn how to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as part of the service. Day Habilitation Services includes all personal assistance needed by the individual. Individuals who receive Group Home or Individualized Supported Living (ISL), or Shared Living may receive this service; their group home or ISL budget will clearly document no duplication in service.

This service does not provide basic child care (a.k.a. "baby sitting"). When services are provided to children the individual support plan (ISP) must clearly document that services are medically necessary to support and promote the development of independent living skills of the child or youth, and are over and above those provided to a child without disabilities. The ISP must

document how the service will be used to reinforce skills or lessons taught in school, therapy or other settings and neither duplicates nor supplants the services provided in school, therapy or other settings. The ISP must also clearly document the service is not supplanting the responsibilities of the primary caregiver. ISPs must include outcomes and action steps individualized to what the participant wishes to accomplish, learn and/or change. The Utilization Review Committee, authorized under 9 CSR 45-2.017 has the responsibility to ensure all services authorized are necessary based on the needs of the individual and ensures that Day Habilitation services is not utilized in lieu of basic child care that would be provided to children without disabilities.

Day habilitation services are provided at a stand-alone licensed or certified day program facility, which is not physically connected to the participant's residence. Costs for transporting the participant from their place of residence to the day program site are not included in the day service rate, and waiver transportation may be provided and separately billed.

Medical Exception:
Exceptional medical supports funding shall be utilized to provide enhanced services as prescribed and identified through the individual assessment and planning process to meet medical needs which require the following: services from a Certified Nursing Assistance (CNA), services from a licensed practical nurse (LPN), or RN within their scope of practice as prescribed by the state, or, for mobility, appropriately trained staff. The process must include the identification and rationale for staffing ratios and the level of direct care provider to meet the identified needs and be clearly documented in their service plan. The process shall include a component of professional assessment by licensed interdisciplinary team member (RN, primary care physician, OT, PT, SLP, etc.).

The intent of the Medical Exception Day Service is to provide an enhanced level of services and supports to individuals requiring the following:
• Direct care, assessment, care coordination and/or planning by a RN or an LPN (under the direct supervision and oversight of an RN) within their scope of practice and/or
• Nursing tasks that are delegated by a RN and performed by a Unlicensed Health Care Personnel under the direct supervision and oversight of a RN

Unlicensed Health Care Personnel shall be defined as the following:
• a DHSS Certified Restorative Aide
• a DHSS Certified Medication Technician(CMT)
• a DHSS Certified Nursing Assistant (CNA)
• a DHSS Certified Level I Medication Aide(LIMA)
• a DMH DD Certified Medication Aide or
• a DMH DD Direct Support Professional
This is to promote individuals ability to access community based services and integration to the fullest extent of their capabilities. A separate rate and code modifier is available for this service.

Requests for Exceptional medical supports shall be submitted to the Utilization Review Committee and include the following documentation:
• Written Support Plan which includes clinical outcome data with criteria for reduction of supports as relevant to the identified medical condition(s).
• Written documentation noting the individual's assessed need for medical services or mobility services by the individual's medical practitioner.

Behavior Exception:
Exceptional behavioral supports funding may be utilized when an individual is accessing the applied behavior analysis (ABA) services for the purpose of implementing the behavioral strategies and additional supervision supports the person requires to learn necessary skills and develop behaviors that will improve their functioning in the community and day habilitation setting.

A separate rate and procedure code and modifier is available for this service. This is to promote individuals ability to access community based services and integration to the fullest extent of their capabilities. Requests for Exceptional behavior supports shall be submitted to the Utilization Review Committee and include the following documentation:
• Written Support Plan which includes clinical outcome data with criteria for reduction of supports as relevant to the identified target behavior(s).
• Written documentation noting the individual's assessed need for behavioral services by the individual's Board Certified Behavior Analyst or Qualified Health Care Professional. If this is not an initial request, documentation must include a description of the progress made in the habilitation setting.
• Written documentation that Behavioral services have been authorized and secured for the individual in day habilitation setting.

Meals provided as part of these services do not constitute a full nutritional regimen.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Individuals who receive Group Home, ISL, and Shared Living Services may also receive day habilitation and/or community integration.

A waiver participant's ISP may include any combination of services, but service documentation according to 13 CSR 70-3.030(2)(A) 6. requiring a begin and end time for services reimbursed according to time spent in service delivery will clearly show no duplication or overlap in the time of the day the service is provided, and the place of service must match the billing code.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Habilitation

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
Day Habilitation
Provider Qualifications
License *(specify):*
9 CSR 40-1,2,9
Certificate *(specify):*
9 CSR 45-5.010 certification; CARF, CQL or The Joint Commission.
Other Standard *(specify):*
DMH Contract;
Direct contact staff must have the following:
-A high school diploma or its equivalent;
-Training in CPR and First Aid;
-Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administration training must be updated every two years with successful completion.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional office
Frequency of Verification:
Prior to contract approval and every 3 years; as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

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

In Home Respite

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
In-home respite care is provided to individuals unable to care for themselves, on a short-term basis, because of the absence or need for relief of those persons normally providing the care. To be eligible for in-home respite care, the persons who normally provide care to the individual must be other than formal, paid caregivers. This service is not delivered in lieu of day care for children nor does it take the place of day habilitation. While ordinarily provided on a one-to-one basis, in-home respite may include assisting up to three individuals at a time. The only limitation on total hours provided is that they be necessary to avoid institutionalization and remain within the overall cost effectiveness of each individual's support plan. The service is provided in the individual's place of residence or in a licensed/certified/accredited facility when service is provided in interim periods, at the discretion of the individual/guardian/family, which does not include overnight care. If the service includes overnight care, it must be provided in the individual's place of residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of service is 15 minutes or one day. The only limitation on total hours provided is that they be necessary to avoid institutionalization and remain within the overall cost effectiveness of each individual's plan.

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	Day Habilitation
Agency	Individualized Supported Living
Agency	Residential Habilitation
Individual	Independent Contractor
Agency	Medicaid State Plan personal care, respite, or homemaker services provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In Home Respite

Provider Category:
Agency
Provider Type:
Day Habilitation
Provider Qualifications
License *(specify):*
9 CSR 40-1,2,9
Certificate *(specify):*
9 CSR 45-5.010; CARF; CQL or Joint Commission
Other Standard *(specify):*
DMH Contract;
The agency-based provider of respite must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; the planning team may specify additional qualifications and training necessary to carry out the service plan.
Verification of Provider Qualifications
Entity Responsible for Verification:
Agency verifies qualification of relatives employed by agencies; oversight by regional office
Frequency of Verification:
Agency verifies upon hiring and as needed based on supervision; regional office monitors provider every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In Home Respite

Provider Category:
Agency
Provider Type:
Individualized Supported Living
Provider Qualifications
License *(specify):*
9 CSR 40-1,2,4,6
Certificate *(specify):*
9 CSR 45-5.010; CARF; CQL or Joint Commission
Other Standard *(specify):*
DMH Contract;
The agency-based provider of respite must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; the planning team may specify additional qualifications and training necessary to carry out the service plan.
Verification of Provider Qualifications
Entity Responsible for Verification:
Agency verifies qualification of relatives employed by agencies; oversight by Regional Office
Frequency of Verification:
Agency verifies upon hiring and as needed based on supervision; regional office monitors provider every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In Home Respite

Provider Category:
Agency
Provider Type:
Residential Habilitation
Provider Qualifications
License *(specify):*

9 CSR 40-1,2,4,5
9 CSR 40-1,2,4,7
Certificate *(specify):*
9 CSR 45-5.010; CARF; CQL or Joint Commission
Other Standard *(specify):*
DMH Contract;
The agency-based provider of respite must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; the planning team may specify additional qualifications and training necessary to carry out the service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
Agency verifies qualification of relatives employed by agencies; oversight by regional office
Frequency of Verification:
Agency verifies upon hiring and as needed based on supervision; regional office monitors provider every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In Home Respite

Provider Category:
Individual
Provider Type:
Independent Contractor
Provider Qualifications

License *(specify):*
Missouri State professional license such as RN, LPN, therapist, or counselor.
State statute RSMo 630.050.
Certificate *(specify):*

Other Standard *(specify):*
DMH Contract; Shall not be the individual's spouse; a parent of a minor child (under age 18); nor a legal guardian

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional office staff
Frequency of Verification:
Prior to signed contract; as needed based on service monitoring concerns and as consumer needs change; regional office monitors every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In Home Respite

Provider Category:
Agency
Provider Type:
Medicaid State Plan personal care, respite, or homemaker services provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Medicaid Personal Care Provider Agreement; DMH Contract;
The agency-based provider of respite must be trained and supervised in accordance with the certification or program

enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; the planning team may specify additional qualifications and training necessary to carry out the service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency verifies qualifications of individual employed by agencies; oversight by regional office staff

Frequency of Verification:

Agency verifies upon hiring and as needed based on supervision; regional office monitors provider every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Assistant

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Personal Assistant Services include assistance with any ADL or IADL. Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, care of adaptive equipment, meal preparation, feeding, and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation, and leisure activities. Assistance with IADLs includes accompaniment, cueing and minor problem-solving necessary to achieve increased independence, productivity and inclusion in the community.

While ordinarily provided on a one-to-one basis, personal assistance may include assisting up to three (3) individuals at a time. With written approval from the Regional office Director personal assistant services may be delivered to groups of four (4) to six (6) persons when it is determined the needs of each person in the group can be safely met.

Personal assistance may also include the use of remote monitoring technology covered under the Assistive Technology service, also in this waiver. The personal assistant may directly perform some activities and support the individual in learning how to perform others; the planning team determines the composition of the service and assures it does not duplicate, nor is duplicated by, any other service provided to the individual.

For self-directed supports Team Collaboration allows the individual's employees to participate in the support plan and to meet as a team to ensure consistency in its implementation. A team meeting also can be convened by the individual or their designated representative for the purposes of discussing specific needs of the individual, the individualized progress towards outcomes, and other related concerns. Team collaboration can be included in the individual budget up to 120 hours per plan year.

For agency-based personal assistant services, team collaboration is included in the unit rate.

Relatives as Providers

Personal assistant services shall not be provided by an individual's spouse; a parent or a step-parent of an individual under age 18; a legal guardian; nor the employer of record/or a designated representative for the individual. Personal assistant services may otherwise be provided to a person by a member(s) of his or her family when the person is not opposed to the family member providing the service and the service to be provided does not primarily benefit the family unit, is not a household task family members expect to share or do for one another when they live in the same household, and otherwise is above and beyond typical activities family members provide for another adult family member without a disability.

In case of a paid family member the support plan must reflect:
• The individual is not opposed to the family member providing services;
• The services to be provided are solely for the individual and not task household tasks expected to be shared with people living in family unit;
• The planning team determines the paid family member providing the service best meet the individual's needs;
• A family member will only be paid for the hours authorized in the support plan and at no time can these exceed 40 hours per week. Any support provided above this amount would be considered a natural support or the unpaid care that a family member would typically provide

Family is defined as: A family member is defined as a parent, step parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild.

Family members approved to provide personal assistant services may be employed by an agency or employed by the individual/guardian or designated representative using an approved FMS provider. If the person employs his/her own workers using an approved FMS provider, the family member serving as a paid personal assistant shall not also be the designated representative/common law employer.

Relation to State Plan Personal Care Services
Personal care services under the state plan differ in service definition, in limitations of amount and scope, and in provider type and requirements from personal assistant services under the waiver. When an individual's need for personal assistance is strictly related to ADLs and can be met through the MO HealthNet state plan personal care program administered by the Division of Senior and Disability Services (DSDS), he or she will not be eligible for personal assistant services under the waiver, in accordance with the requirement that state plan services must be utilized before waiver services can be provided.

After State Plan Services are utilized, DD Waiver personal assistant may be authorized when:
• State plan limits on number of units for personal care are reached and more assistance with ADLs and/or IADLs is needed;
• Person requires personal assistance at locations outside of their residence;
• The individual has medical needs, and they require a more highly trained personal assistant than is available under state plan.
• The person shall utilize agency-based state plan personal care prior to self-directing his or her waiver personal assistant services (may not self-direct state plan services).

When waiver personal assistant is authorized to adults also eligible for state plan personal care, the support coordinator must consult and coordinate the waiver support plan with the DSDS service authorization system.

Personal care services are provided to children with disabilities according to the federal mandates of the Early Periodic Screening, Diagnosis and Treatment program. Personal Assistant needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be utilized before waiver services can be provided. Personal Assistant services authorized through the waiver shall not duplicate state plan personal care services. State plan personal care services for children are coordinated through the Bureau of Special Health Care Needs (BSHCN).

When waiver personal assistant is authorized for children also eligible for state plan personal care, the support coordinator must consult and coordinate with the BSHCN service authorization system.

Non-Duplication of Services
Personal Assistant services shall not duplicate other services. Personal assistance is not available to waiver recipients who reside in community residential facilities (Group Homes and Residential Care Centers). Persons who receive ISL services shall not receive personal assistant services at their home but may receive this service outside the home - as long as not included in the ISL budget.

Medical Personal Assistance
To assist in meeting the specialized medical needs for the individual as identified by the team and documented in the ISP, the following must have been met:
• The interdisciplinary team has identified and outlined the need to pursue more intensive support for medically related issues;
• The need must be documented by a physician or advanced practice nurse and maintained on file;
• Prior to approval of funding for medical personal assistance the ISP has gone through the local UR review process to determine the above have been completed.
• Dependent upon the scope of service, a registered professional nurse may be required to provide oversight in accordance with the Missouri Nurse Practice Act.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the individual's need for the service as an alternative to institutional care and the overall cost effectiveness of his or her support plan. Personal Assistant can occur in the person's home and/or community, including the work place. Personal Assistant shall not be provided concurrently with facility-based day habilitation services.

Payment is on a 15 minute, fee for service basis, with different rates for individual and small group services, and, when needed, for enhanced staff qualifications.
Personal Assistant services through EPSDT for eligible persons under age 21 shall be provided and utilized first before the waiver Personal Assistant service is provided. Children have access to EPSDT services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	A MO HealthNet-enrolled provider of personal care services
Agency	Electronic Communication Equipment and Monitoring Company
Agency	Individualized Supported Living Services
Individual	Independent Contractor
Agency	Day Habilitation Services
Individual	Employee of Consumer/Family

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant

Provider Category:
Agency
Provider Type:
A MO HealthNet-enrolled provider of personal care services
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
DMH Contract; DHSS Medicaid Personal Care Enrollment;

The agency-based provider of personal assistance must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; and the planning team may specify additional qualifications and training necessary to carry out the service plan.

Personal Assistant Qualifications and Training
Training will cover, at a minimum:

a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Support Plan.
b. The rights and responsibilities of the employee and the individual, procedures for billing and payment, reporting and documentation requirements, procedures for arranging backup when needed, and who to contact within the Regional Office or TCM entity.
c. Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.

d. Training in abuse/neglect, event reporting, and confidentiality.
e. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
f. CPR and first aid;
g. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
h. Crisis intervention training As needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
i. training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
j. Training in assisting with ADLs and IADLs, as needed by the individual to be served and identified by the team.

Verification of Provider Qualifications

Entity Responsible for Verification:
Agency verifies qualifications of personal assistant; oversight by regional office staff

Frequency of Verification:
Agency verifies upon hiring and as needed based on supervision; regional office monitors provider every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant

Provider Category:
Agency

Provider Type:
Electronic Communication Equipment and Monitoring Company

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The monitoring agency must be capable of simultaneously responding to multiple signals for help from individuals' Personal Emergency Response Systems (PERS) equipment. The monitoring agency's equipment must include a primary receiver, a stand-by information retrieval system and a separate telephone service, a stand-by receiver, a stand-by back up power supply, and a telephone line monitor. The primary receiver and back-up receiver must be independent and interchangeable. The clock printer must print out the time and date of the emergency signal, the PERS individual's Medical identification code (PIC) and the emergency code that indicates whether the signal is active, passive, or a responder test. The telephone line monitor must give visual and audible signals when an incoming telephone line is disconnected for more than 10 seconds. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements including PERS equipment installation, functioning and testing; emergency response protocols; and record keeping and reporting procedures.

Registered and in good standing with the Missouri Secretary of State.

Personal Assistant Qualifications and Training
Training will cover, at a minimum:

a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Support Plan.
b. The rights and responsibilities of the employee and the individual, procedures for billing and payment, reporting and documentation requirements, procedures for arranging backup when needed, and who to contact within the Regional Office or TCM entity.
c. Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.

d. Training in abuse/neglect, event reporting, and confidentiality.
e. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
f. CPR and first aid;
g. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
h. Crisis intervention training As needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
i. training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
j. Training in assisting with ADLs and IADLs, as needed by the individual to be served and identified by the team.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional Offices
Frequency of Verification:
Prior to contract approval or renewal; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant

Provider Category:
Agency
Provider Type:
Individualized Supported Living Services
Provider Qualifications

License *(specify):*

Certificate *(specify):*
DMH Certification for ISL or CARF/CQL/Joint Commission accredited for ISL
Other Standard *(specify):*
DMH Contract;
The agency-based provider of personal assistance must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; and the planning team may specify additional qualifications and training necessary to carry out the service plan.

Personal Assistant Qualifications and Training
Training will cover, at a minimum:

a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Support Plan.
b. The rights and responsibilities of the employee and the individual, procedures for billing and payment, reporting and documentation requirements, procedures for arranging backup when needed, and who to contact within the Regional Office or TCM entity.
c. Information about the specific condition and needs of the person to be served, including his or her physical,

psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.

d. Training in abuse/neglect, event reporting, and confidentiality.
e. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
f. CPR and first aid;
g. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
h. Crisis intervention training As needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
i. training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
j. Training in assisting with ADLs and IADLs, as needed by the individual to be served and identified by the team.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional Office staff
Frequency of Verification:
Prior to contract approval or renewal; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant

Provider Category:
Individual
Provider Type:
Independent Contractor
Provider Qualifications

License *(specify):*
Missouri State professional license such as RN or LPN.
Certificate *(specify):*

Other Standard *(specify):*
DMH Contract; Shall not be the individual's spouse; a parent or a step-parent of an individual under age 18; a legal guardian; nor the employer of record/or a designated representative for the individual.

Personal Assistant Qualifications and Training
Training will cover, at a minimum:

a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Support Plan.
b. The rights and responsibilities of the employee and the individual, procedures for billing and payment, reporting and documentation requirements, procedures for arranging backup when needed, and who to contact within the Regional Office or TCM entity.
c. Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.

d. Training in abuse/neglect, event reporting, and confidentiality.
e. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
f. CPR and first aid;
g. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
h. Crisis intervention training As needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
i. training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
j. Training in assisting with ADLs and IADLs, as needed by the individual to be served and identified by the team.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional office staff

Frequency of Verification:

Prior to signed contract; as needed based on service monitoring concerns and as individual's needs change

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant

Provider Category:

Agency

Provider Type:

Day Habilitation Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DMH Certification for day hab; or CARF/CQL/the Joint Commission accredited for day hab.

Other Standard *(specify):*

DMH Contract;

The agency-based provider of personal assistance must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; and the planning team may specify additional qualifications and training necessary to carry out the service plan.

Personal Assistant Qualifications and Training
Training will cover, at a minimum:

a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Support Plan.
b. The rights and responsibilities of the employee and the individual, procedures for billing and payment, reporting and documentation requirements, procedures for arranging backup when needed, and who to contact within the Regional Office or TCM entity.
c. Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.

d. Training in abuse/neglect, event reporting, and confidentiality.
e. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
f. CPR and first aid;
g. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
h. Crisis intervention training As needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
i. training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
j. Training in assisting with ADLs and IADLs, as needed by the individual to be served and identified by the team.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional office staff.

Frequency of Verification:

Prior to contract approval or renewal; as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Assistant

Provider Category:

Individual

Provider Type:

Employee of Consumer/Family

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Age 18; has completed Abuse and Neglect training/reporting events and training on the ISP; meets minimum training requirements; agreement with individual/designated representative; planning team will specify the qualifications and training the personal assistant will need in order to carry out the service plan; Supervision is provided by the individual or a designated representative in providing service in the home or community consistent with the service plan.

Shall not be the individual's spouse; a parent or a step-parent of an individual under age 18; a legal guardian; nor the employer of record/or a designated representative for the individual.

The individual shall not be opposed to the family member providing care.

The planning team agrees the family member providing the personal assistant service will best meet the individual's needs.

Personal Assistant Qualifications and Training

Training will cover, at a minimum:

a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Support Plan.

b. The rights and responsibilities of the employee and the individual, procedures for billing and payment, reporting and documentation requirements, procedures for arranging backup when needed, and who to contact within the Regional Office or TCM entity.

c. Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.

d. Training in abuse/neglect, event reporting, and confidentiality.

e. Duties of the Personal Assistant will not require skills to be attained from the training requirement;

f. CPR and first aid;

g. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070

h. Crisis intervention training, as needed, due to challenging behavior by the individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;

i. Training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;

j. Training in assisting with ADLs and IADLs, as needed by the individual to be served and identified by the team.

For self directed supports (SDS) the planning team will specify the qualifications and training the personal assistant will need in order to carry out the support plan, where/by whom the assistant will be trained, and the source, method and degree of monitoring but not less than quarterly. To the extent they desire, the individual or designated representative will select the personal assistant and carry out training and supervision.

Individual/guardian or designated representative may exempt the following trainings if:

a. Duties of the Personal Assistant will not require skills to be attained from the training requirement;

b. The personal assistant named above has adequate knowledge or experience in:

• CPR and first aid;

• Medication Administration;

• Crisis Intervention training, as needed, due to challenging behavior by the individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;

• Training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;

• Training in assisting with ADLs and IADLs, as needed by the individual to be served and identified by the team.

Family members employed by the individual or designated representative are supervised by the individual or a designated representative in providing service in the home or community consistent with the service plan.

Family members employed by an agency are supervised by the agency.

Verification of Provider Qualifications

Entity Responsible for Verification:
Consumer; Family; FMS contractor; regional office has oversight

Frequency of Verification:
FMS verifies on behalf of consumer/family upon hire. Prior to signed agreement with regional office and consumer/designated representative; service review as needed based on service monitoring concerns; as consumer needs change.

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:
Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):
Support Broker

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direct
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
A Support Broker provides information and assistance to the individual or designated representative for the purpose of directing and managing supports. This includes practical skills training and providing information on recruiting and hiring personal assistant workers, managing workers and providing information on effective communication and problem-solving. The extent of the assistance furnished to the individual or designated representative is specified in the support plan.

A Support Broker provides the individual or their designated representative with information & assistance (I&A) to secure the

supports and services identified in the support plan.

A Support Broker provides the individual or designated representative with information and assistance (I &A) to:
- establish work schedules for the individual's employees based upon their support plan
- help manage the individual's budget when requested or needed
- seek other supports or resources outlined by the support plan
- define goals, needs and preferences, identifying and accessing services, supports and resources as part of the person centered planning process which is then gathered by the support coordinator for the support plan
- implement practical skills training (recruiting, hiring, managing, terminating workers, managing and approving timesheets, problem solving, conflict resolution)
- develop an emergency back-up plan
- implement employee training
- promote independent advocacy, to assist in filing grievances and complaints when necessary
- include other areas related to providing I&A to individuals/designated representative to managing services and supports.

Support brokers must have a background screening per the Division of DD, be at least 18 years of age and possess a high school diploma or GED.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Support Broker services do not duplicate Support Coordination. Support Brokerage is a direct service.

A Support Broker may not be a parent, guardian or other family member. They cannot serve as a personal assistant or perform any other waivered service for that individual. This service can be authorized for up to 8 hours per day (32 quarter hour units).

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Habilitation
Agency	State Plan Personal Care Provider
Agency	Individualized Supported Living
Agency	Community Integration

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Broker

Provider Category:
Agency
Provider Type:
Day Habilitation
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
9 CSR 45-5.010 certification; or CARF/CQL/the Joint Commission accredited for Day Hab
Other Standard *(specify)*:
DMH Contract; employs qualified support brokers

The support broker must have experience or Division DD approved training in the following areas:
• ability, experience and/or education to assist the individual/designated representative in the specific areas of support as described in the Support Plan

• competence in knowledge of Division of DD policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques
• understanding of support broker responsibilities, of advocacy, person-centered planning, and community services
• understanding of individual budgets and Division of DD fiscal management policies

The planning team may specify any additional qualifications and training the support broker will need in order to carry out their duties as specified in the Support Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional Office
Frequency of Verification:
Prior to contract approval; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Broker

Provider Category:
Agency
Provider Type:
State Plan Personal Care Provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DMH Contract; MO HealthNet Personal Care Enrollment; employs qualified support brokers

The support broker must have experience or Division DD approved training in the following areas:
• ability, experience and/or education to assist the individual/designated representative in the specific areas of support as described in the Support Plan
• competence in knowledge of Division of DD policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques
• understanding of support broker responsibilities, of advocacy, person-centered planning, and community services
• understanding of individual budgets and Division of DD fiscal management policies

The planning team may specify any additional qualifications and training the support broker will need in order to carry out their duties as specified in the Support Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of DD regional office
Frequency of Verification:
Prior to contract approval; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Broker

Provider Category:
Agency
Provider Type:
Individualized Supported Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*
DMH Certification for ISL or Day Hab; or CARF/CQL/the Joint Commission accredited for ISL

Other Standard *(specify):*
DMH Contract; employs qualified support brokers
The support broker must have experience or Division DD approved training in the following areas:
• ability, experience and/or education to assist the individual/designated representative in the specific areas of support as described in the Support Plan
• competence in knowledge of Division of DD policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques
• understanding of support broker responsibilities, of advocacy, person-centered planning, and community services
• understanding of individual budgets and Division of DD fiscal management policies

The planning team may specify any additional qualifications and training the support broker will need in order to carry out their duties as specified in the Support Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
DD regional office

Frequency of Verification:
Prior to contract approval; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Broker

Provider Category:
Agency

Provider Type:
Community Integration

Provider Qualifications

License *(specify):*

Certificate *(specify):*
9 CSR 45-5.010; CARF accredited Community Integration; CQL; or Joint Commission

Other Standard *(specify):*
DMH Contract; employs qualified support brokers

The support broker must have experience or Division DD approved training in the following areas:
• ability, experience and/or education to assist the individual/designated representative in the specific areas of support as described in the Support Plan
• competence in knowledge of Division of DD policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques
• understanding of support broker responsibilities, of advocacy, person-centered planning, and community services
• understanding of individual budgets and Division of DD fiscal management policies

The planning team may specify any additional qualifications and training the support broker will need in order to carry out their duties as specified in the Support Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of DD Regional Office

Frequency of Verification:
Prior to contract approval and every 3 years; as needed based on service monitoring concerns

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:

Applied Behavior Analysis

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

ABA services are designed to help individuals demonstrating significant deficits (challenges) in the areas of behavior, social, and communication skills acquire functional skills in their homes and communities and/or to prevent hospitalizations or out-of-home placements. ABA services may be provided to assist a person or persons to learn new behavior directly related to existing challenging behaviors or functionally equivalent replacement behaviors for identified challenging behaviors. Services may also be provided to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. ABA services includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior.

•The Behavior Support Plan (BSP) should describe strategies and procedures to generalize and maintain the effects of the BSP and to collect data to assess the effectiveness of the plan and fidelity of implementation of the plan.

•The specific skills and behaviors targeted for each individual should be clearly defined in observable terms and measured carefully by direct observation each session.

•The BSP shall include collection of data by the staff, family and or caregivers that are the primary implementers of the plan and the service shall include monitoring of data from continuous assessment of the individual's skills in learning, communication, social competence, and self-care guide to the scope of the individual support plan, which must include separate, measurable goals and objectives with clear definitions of what constitutes mastery.

•Reports regarding the service must include data displayed in graphic format with relevant environmental variables that might affect the target behaviors indicated on the graph. The graph should provide indication of analysis via inclusion of environmental variables including medications and changes in medications, baseline or pre- intervention levels of behavior, and strategy changes.

•Performance-based training for parents, caregivers and significant others in the person's life is also part of the behavior analysis services if these people are integral to the implementation or monitoring of the plan.

ABA services consist of the following components:

• Assessment: ABA services are based on an assessment which identifies functional relationships between behavior and the environment, including contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical variables related to challenging behaviors or situations. The assessment is further composed

of the following elements:
o Behavior identification assessment, by the physician or other qualified health care professional (QHCP), face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.
o Observational Behavioral Follow-up Assessment: Behavioral follow-up assessment(s) may be required to enable the QHCP to finalize or fine-tune the baseline results and plan of care that were initiated in the identification assessment. This service is performed by a technician under the direction of a QHCP or licensed assistant behavior analyst (LaBA). The QHCP or LaBA may or may not be on-site during the face-to-face assessment process. Observational Follow-up is provided to individuals who present with specific destructive behavior(s) (e.g., self-injurious behavior, aggression, property destruction) or behaviors or deficits in communication or social relatedness. Observational Follow-up includes the use of structured observation and/or standardized and non-standardized tests to determine levels of adaptive behavior. Areas assessed may include cooperation, motivation, visual understanding, receptive and expressive language, imitation, requests, labeling, play and leisure and social interactions. Specific destructive behavior(s) assessments include structured observational testing to examine events, cues, responses, and consequences associated with the behavior(s).
o Exposure Behavioral Follow-up Assessment: is administered by the QHCP with the assistance of one or more technicians. Exposure behavioral follow-up assessment includes the QHCP's interpretation of results, discussion of findings and recommendations with primary caregiver(s), and preparation of report. Typical individuals for these services include those with more specific severe destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction). Specific severe destructive behavior(s) are assessed using structured testing to examine events, cues, responses, and consequences associated with the behavior. Exposure Behavioral Follow up Assessment includes exposing the individual to a series of social and environmental conditions associated with the destructive behavior(s). Assessment methods include using testing methods designed to examine triggers, events, cues, responses, and consequences associated with the before mentioned maladaptive behavior(s). This assessment is completed in a structured, safe environment.
• Treatment: Adaptive Behavior Treatment addresses the individual's specific target problems and treatment goals as defined in previous assessments. Adaptive behavior treatment is based on principles including analysis and alteration of contextual events and motivating factors, stimulus-consequence strategies and replacement behavior and monitoring of outcomes. Goals of adaptive behavior treatment may include reduction of repetitive and aberrant behavior, and improved communication and social functioning. Adaptive behavior skill tasks are often broken down into small, measurable units, and each skill is practiced repeatedly until the individual masters it. Adaptive behavior treatment may occur in multiple sites and social settings (e.g., controlled treatment programs with individual alone or in a groups setting, home, or other natural environment). All ABA services are considered short term services whose objectives are to provide changes in patterns of interactions, daily activities and lifestyle including provider family/staff/caregivers skills to teach the individuals supported adaptive skills and skills to more appropriately address problem behaviors. The development of skills in the individual and in the family/staff/caregivers is a key component to these services. In addition it is the essential that the strategies developed are adapted to more typical types of support strategies so that the treatment plan called the BSP is replaced with these more typical strategies as the service is successful.
Adaptive behavior treatment is further composed of the following elements:
o Adaptive Behavior Treatment by Protocol by Technician: is administered by a single technician or LaBA under the direction (on-site or off-site) of the QHCP by adhering to the protocols that have been designed by the QHCP. This service is delivered to the individual alone or while attending a group session.
Adaptive behavior treatment by protocol by technician includes skill training delivered to an individual who, for example, has poor emotional responses (eg, rage with foul language and screaming) to deviation in rigid routines. The technician introduces small, incremental changes to the individual's expected routine along one or more stimulus dimension(s), and a reinforce is delivered each time the individuals appropriately tolerates a given stimulus change until the individual tolerates typical variations in daily activities without poor emotional response.
The QHCP directs the treatment by designing the overall sequence of stimulus and response fading procedures, analyzing the technician-recorded progress data to assist the technician in adhering to the protocol, and judging whether the use of the protocol is producing adequate progress.
o Adaptive Behavior Treatment by Protocol Modification: Unlike the Adaptive Behavior Treatment by Protocol by Technician, Adaptive Behavior Treatment by Protocol Modification is administered by a QHCP or LaBA who is face-to-face with a single individual. The service may include demonstration of the new or modified protocol to a technician, guardian(s), and/or caregiver. For example, Adaptive Behavior Treatment by Protocol Modification will include treatment services provided to a teenager who is recently placed with a foster family for the first time and is experiencing a regression of the behavioral targets which were successfully met the group-home setting related to the individual's atypical sleeping patterns. The clinical social worker modifies the past protocol targeted for desired results to incorporate changes in the context and environment. A modified treatment protocol is administered by the QHCP to demonstrate to the new caregiver how to apply the protocol(s) to facilitate the desired sleeping patterns to prevent sleep deprivation.
o Exposure Adaptive Behavior Treatment with Protocol Modification describes services provided to individuals with one or more specific severe destructive behaviors (eg, self-injurious behavior, aggression, property destruction), with direct supervision by a QHCP which requires two or more technicians face-to-face with the individual for safe treatment. Technicians elicit behavioral effects of exposing the individual to specific environmental conditions and treatments. Technicians record all occurrences of targeted behaviors. The QHCP reviews and analyzes data and refines the therapy using single-case designs; ineffective components are modified or replaced until discharge goals are achieved (eg, reducing destructive behaviors by at least 90%, generalizing the treatment effects across caregivers and settings, or maintaining the treatment effects over time). The treatment is conducted in a structured, safe environment. Precautions may include environmental modifications and/or protective equipment for the safety of the individual or the technicians. Often these services are provided in intensive out-patient, day treatment, or

inpatient facilities, depending on the dangerousness of the behavior.
• Family Adaptive Behavior Treatment Guidance: Family/guardian/caregiver adaptive behavior treatment guidance is administered by a QHCP or LaBA face-to-face with family/guardian(s)/caregiver(s) and involves teaching family/guardian (s)/caregiver(s) to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits.
• Adaptive Behavior Treatment Social Skills Group: Adaptive behavior treatment social skills group is administered by a QHCP or LaBA face-to-face with multiple individuals, focusing on social skills training and identifying and targeting individual patient social deficits and problem behaviors. The QHCP or LaBA monitors the needs of individuals and adjusts the therapeutic techniques during the group, as needed. Services to increase target social skills may include modeling, rehearsing, corrective feedback, and homework assignments. In contrast to adaptive behavior treatment by protocol techniques, adjustments are made in real time rather than for a subsequent services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Behavior Identification Assessment: One assessment every 2 years unless exception is granted.

Exposure Behavioral Follow-Up Assessment, first 30 minute unit: Limited to 1 per day, 5 per week, and 10 per year.

Exposure Behavioral Follow-Up Assessment, additional 30 minute units: Limited to 40 per year.

Exposure Behavioral Follow-Up Assessment can be done by the Registered Behavior Technician (RBT) under the direction of the QHCP that is a Licensed Behavior Analyst (LBA), or under the direction of a LaBA; the service can also be done by the QHCP or LaBA.

Observational Behavioral Follow-up Assessment, first 30 minute unit: Limited to 1 per day and a maximum of 5 per week, 5 per year.

Observational Behavioral Follow-up Assessment, additional 30 minute units: Limited to 4 per day and a maximum of 20 per week, 20 per year.

All Observational Behavior Follow-Up Assessments must be Administered by the RBT under the direction of the QHCP that is a LBA, or under the direction of a LaBA; the service can also be done by the QHCP or LaBA . Units may be used for the development of the initial treatment protocol at 1 unit of the first 30 minutes of Observational Behavioral Follow-up Assessment and 1 unit of the second 30 minutes of Observational Behavior Follow-up Assessment.

Adaptive Behavior by Protocol by Technician, first 30 minute unit: Limited to 1 per day, 5 per week, and 25 per month.

Adaptive Behavior by Protocol by Technician, additional 30 minute units: Limited to 15 per day, 75 per week, and 275 per month.

All Adaptive Behavior by Protocol by Technician must be performed by a RBT or LaBA under the direction of a QHCP that is a LBA. This service must be provided concurrent with Adaptive Behavior Treatment with Protocol Modification by a LBA for at least the equivalent of 5% of the total units provided by the RBT.

Adaptive Behavior Treatment with Protocol Modification, first 30 minute unit: Limited to 1 per day, 5 per week and 25 per month.

Adaptive Behavior Treatment with Protocol Modification, additional 30 minute units: Limited to 15 per day, 55 per week and 110 per month. Extensions may be approved by the DMH, Division of DD's Chief Behavior Analyst, or designee. 10% of units authorized in a plan year for this service would be appropriately utilized for protocol modification and data analysis and that this would require documentation as with all other units in addition to the written modified protocol and graphic display with current data and progress report describing the analysis and effects on intervention strategies related to the analysis.

Exposure Adaptive Behavior Treatment with Protocol Modification, first 60 minute unit: Limited to 1 per day, 5 per week and 25 per month.

Exposure Adaptive Behavior Treatment with Protocol Modification, additional 30 minute units: Limited to 15 per day, 55 per week and 110 per month.

Exposure Adaptive Behavior Treatment with Protocol Modification must receive prior approval by the DMH, Division of DD's Chief Behavior Analyst.

Family Adaptive Behavior Treatment Guidance, 60 minute unit: limited to 1 unit per day, 5 per week and 10 per month. In addition, no more than 8 family members/guardians/caregivers can be present for a unit to be billed. This service can be concurrent to any of the other treatment services.

Adaptive Behavior Treatment Social Skills Group, 90 minute unit: limited to 1 unit per day, 5 per week and 10 per month. In addition, no more than 8 individuals can be present for a unit to be billed. This service can be concurrent to any of the other treatment services.

The services under the Missouri Children with Developmental Disabilities (MOCDDS) Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Health Care Professional (QHCP)
Individual	Qualified Health Care Professional (QHCP)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Applied Behavior Analysis

Provider Category:
Agency

Provider Type:
Qualified Health Care Professional (QHCP)

Provider Qualifications

License *(specify)*:
Graduate degree and Missouri State license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis. RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224 or Missouri State license as an Assistant Behavior Analyst. RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224

Certificate *(specify)*:
Registration as RBT with the Behavior Analyst Certification Board

Other Standard *(specify)*:
DMH contract; ABA services can be provided by a person enrolled in a graduate program for ABA and completing the experience requirements with ongoing supervision by a LBA in the state of Missouri who is a contracted provider for the Division. These services provide by a person as part of the experience requirement and under the supervision of the LBA will be considered as the equivalent of LaBA services for purposes of billing and eligibility to provide particular ABA services.

Verification of Provider Qualifications

Entity Responsible for Verification:
Division of Developmental Disability regional offices

Frequency of Verification:
Initially and at renewal

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Applied Behavior Analysis

Provider Category:
Individual

Provider Type:
Qualified Health Care Professional (QHCP)

Provider Qualifications

License *(specify):*

Graduate degree and Missouri State license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis. RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224 or Missouri State license as an Assistant Behavior Analyst. RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224

Certificate *(specify):*

Registration as RBT with the Behavior Analyst Certification Board

Other Standard *(specify):*

DMH contract; ABA services can be provided by a person enrolled in a graduate program for ABA and completing the experience requirements with ongoing supervision by a LBA in the state of Missouri who is a contracted provider for the Division. These services provide by a person as part of the experience requirement and under the supervision of the LBA will be considered as the equivalent of LaBA services for purposes of billing and eligibility to provide particular ABA services.

Verification of Provider Qualifications

Entity Responsible for Verification:

regional office

Frequency of Verification:

Initially and at renewal

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:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

This service includes PERS, Medication Reminder Systems (MRS) and other electronic technology that protects the health and

welfare of a participant. This service may also include electronic support systems using video, web-cameras, or other technology. However, use of such systems may be subject to due process review. Assistive technology shall not include household appliances or items that are intended for purely diversional or recreational purposes. Assistive technology should be evidenced based, and shall not be experimental.

Electronic support systems using video, web-cameras, or other technology is only available on an individual, case-by-case basis when an individual requests the service and the planning team agrees it is appropriate and meets the health and safety needs of the individual. Remote support technology may only be used with full consent of the individual and his/her guardian and with a completed review by a DMH approved due process committee to ensure the individual's rights are being protected.

Remote support will enable a person to be more independent and less reliant on staff to be physically present with them at all times, in particular for night time supports.

The type of equipment and where placed will depend upon the needs and wishes of the individual and their guardian (if applicable), and will also depend upon the particular company selected by the individual or guardian to provide the equipment. The installation of video monitoring equipment in the home will be done at the direction of the individual. If the home is shared with others the equipment will be installed in such a manner that it does not invade others privacy. The remote device is controlled by the waiver participant and can be turned on or off as needed.

The provider must have safeguards and/or backup system such as battery and generator for the electronic devices in place at the monitoring base and the participants residential living site(s) in the event of electrical outages. The provider must have backup procedures for system failure (e.g., prolonged power outage), fire or weather emergency, participant medical issue or personal emergency in place and detailed in writing for each site utilizing the system as well as in each participants ISP. The ISP must specify the individuals to be contacted by monitoring base staff who will be responsible for responding to these situations and traveling to the participants living site(s). In situations requiring a person to respond to the participants residence, the response time should not exceed 20 minutes. In emergency situations, support staff should call 911.

Waiver participants interested in electronic surveillance/remote support technology must be assessed for risk following the division's risk assessment guidelines posted at http://dmh.mo.gov/docs/dd/riskguide.pdf and must be provided information to ensure an informed choice about the use of equipment versus in- home support staff.

PERS is an electronic device that enables an individual at high risk of institutionalization to secure help in an emergency that is connected to a device and programmed to signal a response center once the help button is activated. The response center is staffed with trained professionals. The service is limited to those who live alone, live with others who are unable to summon help, or who are alone for significant portions of the day, have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision.

A MRS is an electronic device programmed to provide a reminder to a participant when medications are to be taken. The reminder may be a phone ring, automated recording or other alarm. This device is for individuals who have been evaluated as able to self-administer medications with a reminder. The electronic device may dispense controlled dosages of medication and may include a message back to the center if a medication has not been removed from the dispenser. Medications must be set-up by an RN or professional qualified to set-up medications in the State of Missouri.

All electronic device vendors must provide equipment approved by the Federal Communications Commission and the equipment must meet the Underwriters Laboratories, Inc., (UL) standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.

The emergency response activator must be able to be activated by breath, by touch, or some other means and must be usable by persons who are visually or hearing impaired or physically disabled.

Any assistive technology device must not interfere with normal telephone use.

The PERS and MRS must be capable of operating without external power during a power failure at the recipients home in accordance with UL requirements for home health care signaling equipment with stand-by capability and must be portable.

An initial installation fee is covered as well as ongoing monthly rental charges and upkeep and maintenance of the devices.

Any assistive technology devices authorized under this service shall not duplicate services otherwise available through state plan.

MRS and PERS are just two of many different types of assistive technology. More examples of assistive technology that can enable people to be less dependent upon direct human assistance include but are not limited to electronic motion sensor devices, door alarms, web-cams, telephones with modifications such as large buttons, telephones with flashing lights, phones equipped with picture buttons programmed with that person's phone number, devices that may be affixed to a wheelchair or walker to send an alert when someone falls (these may be slightly different than a PERS) text-to-speech software, devices that enhance images for people with low vision, intercom systems.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Costs are limited to $9,000 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.

The services under the Missouri Children with Developmental Disabilities (MOCDDS) Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

If a person's need can't be met within a limit, attempts will be made to locate another funding source or an exception may be approved by the by the director or designee to exceed the limit if exceeding the limit will result in decreased need (units) of one or more other services. The service plan must document exceeding the limit for the service that will result in a decreased need of one or more other services. If it is determined the needs of a significant number of individuals cannot be met within the limitation, an amendment will be requested to increase the amount of the limitation.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Electronic Communication Equipment and Monitoring Company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Electronic Communication Equipment and Monitoring Company
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The monitoring agency must be capable of simultaneously responding to multiple signals for help from individuals' PERS equipment. The monitoring agency's equipment must include a primary receiver, a stand-by information retrieval system and a separate telephone service, a stand-by receiver, a stand-by back up power supply, and a telephone line monitor. The primary receiver and back-up receiver must be independent and interchangeable. The clock printer must print out the time and date of the emergency signal, the PERS individual's PIC and the emergency code that indicates whether the signal is active, passive, or a responder test. The telephone line monitor must give visual and audible signals when an incoming telephone line is disconnected for more than 10 seconds. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements including PERS equipment installation, functioning and testing; emergency response protocols; and record keeping and reporting procedures.

DMH Contract.

Registered and in good standing with the Missouri Secretary of State.
Verification of Provider Qualifications

Entity Responsible for Verification:
Regional offices
Frequency of Verification:
Prior to contract approval or renewal; as needed based on service monitoring concerns

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:
Community Integration

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
Community Integration assists and/or teaches participation in community activities. Community Integration does not include assistance with ADL, unless it is combined with a community integration activity. These activities and/or skills are needed to be a participating member of a community, which may include, but not limited to, becoming a member of social events/clubs, recreational activities, volunteering, participating in organized worship or spiritual activities. The following are examples of ADL that are not included in community integration: grocery/clothing shopping, haircut, etc. Community Integration expectations are for individuals to interact with the broader community on a regular basis, including community activities that enable individuals to engage directly, throughout the day, with people who are not paid to provide them with services. In addition, community activities should be organized for the benefit of the individuals to foster relationships with the broader community. Transportation costs related to the provision of this service in the community are included in the service rate. This service supports naturalized involvement in order to become a fully participating member of the community.

Personal assistance may be a component of Community Integration services, but may not comprise the entirety of the service.

A waiver participant's ISP may include any combination of services, but service documentation according to 13 CSR 70-3.030(2)(A) 6. requiring a begin and end time for services reimbursed according to time spent in service delivery will clearly show no duplication or overlap in the time of the day the service is provided, and the place of service must match the billing code.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limitation:

This service is limited to 25 hours a week.

Group community integration may not have more than 4 individuals in a group.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Integration
Agency	Day Habilitation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration

Provider Category:
Agency
Provider Type:
Community Integration
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
9 CSR 45-5.010 certification, CARF accredited Community Integration, CQL, or The Joint Commission
Other Standard *(specify)*:
DMH Contract; Direct contact staff must have the following:
-A high school diploma or its equivalent;
-Training in CPR and First Aid;
-Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administration training must be updated every two years with successful completion.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional Office
Frequency of Verification:
Prior to contract approval and every three years; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration

Provider Category:
Agency
Provider Type:
Day Habilitation

Provider Qualifications

License *(specify):*
9 CSR 40-1,2,9
Certificate *(specify):*
9 CSR 45-5.010 certification, CARF, CQL, or The Joint Commission
Other Standard *(specify):*
DMH Contract;
Direct contact staff must have:
A high school diploma or its equivalent; training in CPR and First Aid;
Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administration training must be updated every two years with successful completion.

Verification of Provider Qualifications

Entity Responsible for Verification:
regional office
Frequency of Verification:
Prior to contract approval and every three years; as needed based on service monitoring concerns.

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:
Community Specialist

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
A community specialist is used when specialized supports are needed to assist the individual in achieving outcomes in the support plan.

Community specialist services includes professional observation and assessment, individualized program design and

implementation and consultation with caregivers. This service may also, at the choice of the individual designated representative, include advocating for the individual, and assisting the individual in locating and accessing services and supports within their field of expertise.

The services of the community specialist assist the individual and the individual's caregivers to design and implement specialized programs to enhance self direction, independent living skills, community integration, social, leisure and recreational skills.

This service shall not duplicate other waiver services including but not limited to: ABA or Personal Assistant services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Community specialist, a direct waiver service, differs in service definition and in limitations of amount and scope from State plan TCM for person with developmental disabilities. In the latter, there are waiver administrative functions performed by a support coordinator through state plan TCM that fall outside the scope of community specialist, such as LOC determination, free choice of waiver and provider, due process and right to appeal. Additionally, Division of DD support coordinators facilitate services and supports, authorized in the support plan, through the regional office utilization review and authorization process.

A Community Specialist shall not be a parent, step-parent, guardian or other family member.

A unit of service is 1/4 hour.

The services under the Missouri Children with Developmental Disabilities (MOCDDS) Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Individualized Supported Living
Agency	Day Habilitation
Agency	Community Integration
Individual	Qualified Community Specialist
Agency	State Plan Personal Care Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Specialist

Provider Category:
Agency
Provider Type:
Individualized Supported Living
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Certified by DMH under 9 CSR 45-5.010 or accredited by CARF; CQL or the Joint Commission as a lead agency for ISL Services;
Other Standard *(specify)*:
DMH Contract; Employs an individual with a Bachelors degree from an accredited university or college plus one year experience, or a RN (with an active license in good standing, issued by the Missouri State Board of Nursing) or

an Associates degree from an accredited university or college plus three years of experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of DD regional office

Frequency of Verification:

Prior to contract approval or every 3 years; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Specialist

Provider Category:

Agency

Provider Type:

Day Habilitation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by DMH under 9 CSR 45-5.010 or accredited by CARF; CQL or the Joint Commission

Other Standard *(specify):*

DMH Contract; employs an individual with a Bachelors degree from an accredited university or college plus one year experience, or a RN (with an active license in good standing, issued by the Missouri State Board of Nursing) or an Associates degree from an accredited university or college plus three years of experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of DD regional office

Frequency of Verification:

Prior to contract approval or every 3 years; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Specialist

Provider Category:

Agency

Provider Type:

Community Integration

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by DMH under 9 CSR 45-5.010; CARF accredited Community Integration; CQL or the Joint Commission

Other Standard *(specify):*

DMH Contract; employs an individual with a Bachelors degree from an accredited university or college plus one year experience, or a RN (with an active license in good standing, issued by the Missouri State Board of Nursing) or an Associates degree from an accredited university or college plus three years of experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of DD regional office

Frequency of Verification:

Prior to contract approval or every 3 years; as needed based on service monitoring concerns

Appendix C: Participant Services

Service Type: Other Service
Service Name: Community Specialist

Provider Category:
Individual
Provider Type:
Qualified Community Specialist
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
DMH Contract; An individual with a Bachelors degree from an accredited university or college plus one year experience, or a RN (with an active license in good standing, issued by the Missouri State Board of Nursing) or an Associates degree from an accredited university or college plus three years of experience.
Verification of Provider Qualifications
Entity Responsible for Verification:
Division of DD regional office
Frequency of Verification:
Prior to contract approval or as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Specialist

Provider Category:
Agency
Provider Type:
State Plan Personal Care Provider
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
DMH Contract, Agency employs an individual with a Bachelors degree from an accredited university or college plus one year experience, or a RN (with an active license in good standing, issued by the Missouri State Board of Nursing), or an Associates degree from an accredited university or college plus three years of experience to direct or consult with its operation; DHSS Medicaid Personal Care Enrollment
Verification of Provider Qualifications
Entity Responsible for Verification:
Division of DD regional office
Frequency of Verification:
Prior to contract approval; as needed based on service monitoring concerns

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:
Crisis Intervention

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.

Crisis intervention may be provided in any setting and includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.

Individuals with developmental disabilities are occasionally at risk of being moved from their residences to institutional settings because the person, or his or family members or other caretakers, are unable to cope with short term, intense crisis situations. Crisis intervention can respond intensively to resolve the crisis and prevent the dislocation of the person at risk. The consultation which is provided to caregivers also helps to avoid or lessen future crises. This service is a cost effective alternative to placement in an ICF-ID.

Specific crisis intervention service components may include the following:
Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis;
Assessing which components are the most effective targets of intervention for the short term amelioration of the crisis;
Developing and writing an intervention plan;
Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions, and following-up to ensure positive outcomes from interventions or to make adjustments to interventions;
Providing intensive direct supervision when a consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others;
Assisting the consumer with self care when the primary caregiver is unable to do so because of the nature of the consumer's crisis situation; and
Directly counseling or developing alternative positive experiences for consumers who experience severe anxiety and grief when changes occur with job, living arrangement, primary care giver, death of loved one, etc.
Temporary day habilitation services as in a crisis drop in center
Temporary 24 hour care in a crisis bed of a residence

Providers of crisis intervention shall consist of a team under the direction and supervision of a psychologist, counselor or social

worker licensed by the State of Missouri (RSMo. 1994, Chapter 337). Alternately, the supervisor may be employed by the State of Missouri as a psychologist, clinical social worker, behavior analyst or in an equivalent position. All team members shall have at least one year of work experience in serving persons with developmental disabilities, and shall, either within their previous work experience or separately, have a minimum of 40 hours training in crisis intervention techniques prior to providing services.

Crisis teams may be agency based (certified or accredited ISL lead agencies, day habilitation providers, and group homes, or Division of DD regional offices and habilitation centers), or they may stand alone.

The scope of the waiver crisis intervention service is significantly above and beyond the scope of the state plan service and is meant to be provided by a team, not a single individual. It would be extremely rare for a crisis situation involving a DD waiver participant to be resolved within 60 minutes, and by a person without specialized training working with people with developmental disabilities.

Many crisis situations in the DD system may be due to an environmental situation where the individual does not have the language skills to communicate their discomfort or distress, and the average provider of traditional "talk therapy" may not have the experience, skills and educational background to appropriately address this need.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Crisis Intervention services are expected to be of brief duration (4 to 8 weeks, maximum). When services of a greater duration are required, the individual should be transitioned to a more appropriate services program such as counseling, or respite.
Crisis intervention needs for the eligible person that can be met through state plan, including EPSDT crisis services, "for eligible persons under age 21", as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be utilized before waiver services can be provided.

The services under the Missouri Children with Developmental Disabilities (MOCDDS) Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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	Crisis Agency
Agency	ISL Lead Agency; Day Habilitation; or Residential Habilitation Provider Agency
Agency	Division of DD Regional Offices and Habilitation Centers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:
Agency
Provider Type:
Crisis Agency
Provider Qualifications
License *(specify)*:
Psychologist, Counselor or Social Worker licensed under RSMo, Chapter 337
Certificate *(specify)*:

Other Standard *(specify)*:
DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of DD Regional Office

Frequency of Verification:

Prior to contract approval or renewal; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:

Agency

Provider Type:

ISL Lead Agency; Day Habilitation; or Residential Habilitation Provider Agency

Provider Qualifications

License *(specify):*

Psychologist, Counselor or Social Worker licensed under RSMo. Chapter 337

Certificate *(specify):*

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of DD regional office

Frequency of Verification:

Prior to contract approval or renewal; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:

Agency

Provider Type:

Division of DD Regional Offices and Habilitation Centers

Provider Qualifications

License *(specify):*

Psychologist, Counselor or Social Worker licensed under RSMo., Chapter 337;

Certificate *(specify):*

Other Standard *(specify):*

Supervisor may be employed by the State of Missouri as a psychologist, clinical social worker or equivalent position exempt from licensure, but who meets the requirements of a QDDP.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of DD regional office and DMH Contract Unit Staff

Frequency of Verification:

Prior to contract approval or renewal; as needed based on service monitoring concerns

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-Home/Vehicle Modification

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Those physical adaptations, required by the participant's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the community and without which, the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant, but shall exclude adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation. Adaptations may be approved for living arrangements (houses, apartments, etc.) where the individual lives, owned or leased by the individual, their family or legal guardian. These modifications can be to the individual's home or vehicle.

The following vehicle adaptations are specifically excluded in the waiver: adaptations or improvements to the vehicle that are of a general utility, and are not of direct medical or remedial benefit to the individual; purchase or lease of a vehicle; and regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modification.

All adaptations must be recommended by an Occupational or Physical Therapist. Plans for installations should be coordinated with the therapist to ensure adaptations will meet the needs of the individual as per the recommendation. All services shall be provided in accordance with applicable State or local building codes.

Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

The services under the Missouri Children with Developmental Disabilities (MOCDDS) Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Costs are limited to $7,500 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.

If a person's need can't be met within a limit, attempts will be made to locate another funding source or an exception may be approved by the by the director or designee to exceed the limit if exceeding the limit will result in decreased need (units) of one or more other services. The service plan must document exceeding the limit for the service that will result in a decreased need of one or more other services. If it is determined the needs of a significant number of individuals cannot be met within the limitation, an amendment will be requested to increase the amount of the limitation.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Contractor
Individual	Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations-Home/Vehicle Modification

Provider Category:
Agency
Provider Type:
Contractor
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Must have applicable business license and meet applicable building codes; DMH Contract
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional offices
Frequency of Verification:
Prior to contract approval or renewal; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations-Home/Vehicle Modification

Provider Category:
Individual
Provider Type:
Contractor
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Must have applicable business license and meet applicable building codes; DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional offices

Frequency of Verification:
Prior to contract approval or renewal; as needed based on service monitoring concerns

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:
Individualized Skill Development

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope)*:
Individualized Skill Development focuses on complex skill acquisition/development, to assist the individual in achieving maximum independence in home and community-based settings. This includes but is not limited to cooking, laundry, shopping, budgeting, paying bills, and accessing public transportation. The service assists the participant to acquire life skills necessary for independent living. When applicable, this should be completed in the community. Transportation costs related to the provision of this service in the community are included in the service rate. Individualized Skill Development differs from the Personal Assistant service in that a personal assistant may directly perform activities or may support the individual to perform ADLs and IADLs as part of the service.

The UR Committee, authorized under 9 CSR 45-2.017 has the responsibility to ensure all services authorized are necessary based on the needs of the individual.

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

This service is an outcome based service. The outcome will be clearly identified in the individualized support plan and progress will be updated at each plan meeting and/or revision. The service is utilized for the development of a clearly identified skill or skill set.

ISPs must include outcomes and action steps individualized to what the participant wishes to accomplish, learn and/or change, which includes a task analysis of the identified learning objective.

If a person's need can't be met within a limit, attempts will be made to locate another funding source or an exception may be approved by the by the director or designee to exceed the limit if exceeding the limit will result in decreased need (units) of one or more other services. The service plan must document exceeding the limit for the service that will result in a decreased need of one or more other services. If it is determined the needs of a significant number of individuals cannot be met within the limitation, an amendment will be requested to increase the amount of the limitation.

No more than 20 hours a week shall be authorized annually.

Individuals who receive Group Home, ISL, or Shared Living may not receive this service because it is encapsulated within these aforementioned services and would cause duplication. A person who receives these services may receive Day Habilitation, but may not receive Individualized Skill Development at the Day Habilitation location.

When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities.

This service may not be provided by a family member or guardian.

Group Individualized Skill Development may not have more than 4 individuals in a group.

A national/state credentialed staff trained in skill development will be required.

Payment is on a 15 minute, fee for service basis.

A waiver participant's ISP may include any combination of services, but service documentation according to 13 CSR 70-3.030(2)(A) 6. requiring a begin and end time for services reimbursed according to time spent in service delivery will clearly show no duplication or overlap in the time of the day the service is provided, and the place of service must match the billing code.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Habilitation
Agency	Individualized Skill Development

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individualized Skill Development

Provider Category:

Agency

Provider Type:

Day Habilitation
Provider Qualifications
License *(specify):*
9 CSR 40-1,2,9
Certificate *(specify):*
9 CSR 45-5.010 certification, CARF, CQL, or The Joint Commission
Other Standard *(specify):*
DMH Contract;portfolio process;
Direct contact staff must have:
A high school diploma or its equivalent; training in CPR and First Aid; Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administration training must be updated every two years with successful completion.
Verification of Provider Qualifications
Entity Responsible for Verification:
regional office
Frequency of Verification:
Prior to contract approval and every three years; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individualized Skill Development

Provider Category:
Agency
Provider Type:
Individualized Skill Development
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified by DMH under 9 CSR 45-5.010 or accredited by CARF; CQL or Joint Commission
Other Standard *(specify):*
DMH Contract; portfolio process
Direct contact staff must have the following:
-A high school diploma or its equivalent;
-Training in CPR and First Aid;
-Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administration training must be updated every two years with successful completion.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional Office
Frequency of Verification:
Prior to contract approval; and every 3 years; as needed based on service monitoring concerns

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:
Out of Home Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
Out of home respite is care provided outside the home in a licensed, accredited or certified waiver residential facility, ICF/ID or State Habilitation Center by trained and qualified personnel for a period of no more than 60 days annually, unless a written exception is granted from the Regional Office Director. The need for this service has to be an identified need through the planning process which would include the individual, guardian if applicable, the primary caregiver, other family members, support coordinator, and any other parties the individual requests. The purpose of respite care is to provide planned relief to the customary caregiver and is not intended to be permanent placement. Federal Financial Participation (FFP) is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Out of Home Respite is a service used on a short-term basis because of the absence or need for relief of those persons who normally provide care for the individual. Out of home respite is limited to no more than 60 days annually, unless a written exception is granted from the Regional Office Director. The 60 days may be consecutive, unless the service is provided in an ICF/ID or State Habilitation Center. Out of home respite provided in an ICF/ID or State Habilitation Center cannot exceed 30 days.

If a person's need can't be met within a limit, attempts will be made to locate another funding source or an exception may be approved by the by the director or designee to exceed the limit if exceeding the limit will result in decreased need (units) of one or more other services. The service plan must document exceeding the limit for the service that will result in a decreased need of one or more other services. If it is determined the needs of a significant number of individuals cannot be met within the limitation, an amendment will be requested to increase the amount of the limitation.

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	Community Residential Facility
Agency	State-operated ICF/ID

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Out of Home Respite

Provider Category:
Agency
Provider Type:
Community Residential Facility
Provider Qualifications
License *(specify):*
9 CSR 40-1,2,4,5
Certificate *(specify):*
9 CSR 45-5.010; CARF; CQL or the Joint Commission
Other Standard *(specify):*
DMH Contract
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional offices
Frequency of Verification:
Prior to contract approval; service review every 3 years; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Out of Home Respite

Provider Category:
Agency
Provider Type:
State-operated ICF/ID
Provider Qualifications
License *(specify):*

Certificate *(specify):*
13 CSR 15-9.010
Other Standard *(specify):*
In good standing with DHSS.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHSS ICF/ID Unit
Frequency of Verification:
Annual

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:
Person Centered Strategies Consultation

HCBS Taxonomy:

Category 1: 17 Other Services

Sub-Category 1: 17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*
This service involves consultation to the individual's support team to improve the quality of life for the individual through the development of and implementation of positive, proactive and preventative, Person Centered Strategies and a modified environment and/or life style for the individual. Person Centered Strategies Consultation (PCSC) involves evaluating a person's setting, schedule, typical daily activities, relationships with others that make up the supports for an individual including paid staff/paid family and unpaid natural supports. The evaluation leads to changes in strategies including such things as re-arranging the home to reduce noise and stimulation, adding a personal quiet area to allow the individual to get away from annoying events, teaching skills to promote more positive interactions between the individual and supporting staff or family. Evaluation may involve identifying skills that would help the individual to have a better quality of life and assist the support staff/family to teach these meaningful skills to the individual and identify ways to proactively prevent problem situations and assisting the individual and support staff/family to use these new strategies and problem solving techniques for the individual. Such strategies developed could include: clarifying the expectations for the individual and all members of the support team, and establishing positive expectations or rules for the individual with the support team learning to change their system to support in these more positive ways, improving recognition of desirable actions and reduction of problematic interactions that might evoke undesirable responses from the individual. A large part of the consultation will involve assisting the support system to develop a sustainable implementation plan and to insure a high fidelity of implementation and consistency of use of the strategies to assist and support the individual. This is not a direct therapy type service, for example the consultant's interaction with the individual should be pleasant and positive, but it is not this interaction that improves the quality of the person's life, rather the changes made to the person's support system, especially those focusing on implementation of identified strategies make the difference for the individual.

PCSC might work towards improved quality of life for the individual through training of support persons and developing a way for the support system to monitor and evaluate the interactions and systems to establish increased opportunities for teaching and practice of necessary skills by the individual, increasing recognition of desirable actions by the individual and the support team, increased frequency and types of positive interactions by support persons with and by the individual, and assisting the individual and support team to arrange practice opportunities such as social skills training groups or arranging a system of coaching and prompting for desirable actions in situations that commonly are associated with problems. The consultant might establish and lead such practice opportunities while coaching support person to continue the practice when the service is discontinued.

The unit of service is one-fourth hour. This is a short term service that is not meant to be on going, the typical duration of service is to be twelve months or less.

This service is not to be provided for development or implementation of BSPs or functional assessment as these services require licensure as a behavior analyst, psychologist, counselor or social worker with specialized training in behavior analysis. However, this service might work in conjunction with a behavior analysis service provider to develop and establish a support system that can implement strategies towards a good quality of life for the individual.

PCSC differs from the ABA Service in that PCSC the focus and whole scope of the service is on identifying barriers to a good quality of life and improving proactive, preventative and teaching based strategies to increase desirable, healthy skills and thus reduce problem situations. In addition, the PCSC will require providers with a less involved level of training and experience than ABA.

Outcomes expected for this service are as follows:
1. Written document describing the results of the evaluation of the system to identify problem situations, strategies and practices and relate these to the quality of life for the focus individual.
2. Summary of recommended strategies developed with the support team to address the identified problems and practices based on the evaluation.
3. Training for the individual and support team to implement the strategies with fidelity and collect data to determine effectiveness of the strategies that will assist the individual in achieving a good quality of life.
4. A written document that is incorporated into the ISP to insure the implementation of the new strategies with fidelity and consistency by the support team after the PCSC is completed.

Documentation for the service:
1. Identification of the outcome being addressed during the service unit(s) for a particular session.
2. Description of progress towards the outcome.
3. Actions steps and planning for the next service sessions including a timeline and steps necessary to achieve the outcome.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This is a short term service that is not meant to be on going, the typical duration of service is to be twelve months or less.

Behavioral Health services under EPSDT do not include Person Centered Strategies services.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Person Centered Strategies Consultant
Agency	Agency employing a Person Centered Strategies Consultant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Person Centered Strategies Consultation

Provider Category:
Individual
Provider Type:
Person Centered Strategies Consultant
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
An individual must have a DMH contract.
This service can be provided by an individual who is a qualified Person Centered Strategies Consultant. A Person Centered Strategies Consultant is a person with a bachelor's degree with special training, approved by the Division, related to the theory and practice of Person Centered Strategies for individuals with intellectual and developmental disabilities, or ABA and implementation of Person Centered Approaches.

Training will be approved by Division of DD staff if the training syllabus describes positive, proactive intervention strategies, quality of life variables and evaluation and improvement strategies and system wide implementation of evidenced based practices. This includes for example: the Tools of Choice training with additional coaching of tools

training; College course work f or example within a special education department involving implementation of Tiered Supports strategies; training from a state agency on implementation of tiered supports and person centered strategies and quality of life.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional office

Frequency of Verification:

Prior to contract approval; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Person Centered Strategies Consultation

Provider Category:

Agency

Provider Type:

Agency employing a Person Centered Strategies Consultant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An agency must have a DMH contract.

This service can be provided by an agency employing a Qualified Person Centered Strategies Consultant. A Person Centered Strategies Consultant is a person with a bachelor's degree with special training, approved by the Division, related to the theory and practice of Person Centered Strategies for individuals with intellectual and developmental disabilities, or ABA and implementation of Person Centered Approaches.

Training will be approved by Division of DD staff if the training syllabus describes positive, proactive intervention strategies, quality of life variables and evaluation and improvement strategies and system wide implementation of evidence based practices. This includes for example: The Tools of Choice Training with additional coaching of tools training; College course work for example within a special education department involving implementation of Tiered Supports strategies; training from a state agency on implementation of tiered supports and person centered strategies and quality of life.

Verification of Provider Qualifications

Entity Responsible for Verification:

regional office

Frequency of Verification:

Prior to contract approval; as needed based on service monitoring concerns

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 (Adaptive Equipment)

HCBS Taxonomy:

Category 1: 14 Equipment, Technology, and Modifications

Sub-Category 1: 14031 equipment and technology

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*
Specialized medical equipment and supplies includes devices, controls, or appliances, specified in the service plan, which enable participants to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live.

Includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, durable and non-durable medical equipment and supplies, and equipment repairs when the equipment, supplies and repairs are not covered under the Medicaid State Durable Medical Equipment (DME) plan. Includes incontinence supplies.

Items reimbursed with waiver funds, shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Costs are limited to $7,500 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.
Other specialized equipment, supplies and equipment repair needs for the eligible person that can be met through state plan, including EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Further, this waiver service may also be authorized for items/repairs not covered under state plan and falls within the waiver service definition described above.

If a person's need can't be met within a limit, attempts will be made to locate another funding source or an exception may be approved by the by the director or designee to exceed the limit if exceeding the limit will result in decreased need (units) of one or more other services. The service plan must document exceeding the limit for the service that will result in a decreased need of one or more other services. If it is determined the needs of a significant number of individuals cannot be met within the limitation, an amendment will be requested to increase the amount of the limitation.

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 & Supply

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies (Adaptive Equipment)

Provider Category:
Agency

Provider Type:
Medical Equipment & Supply

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DMH Contract; Registered and in good standing with Missouri Secretary of State; The provider must be enrolled with MO HealthNet as a state plan DME Provider or currently possess a DMH contract to provide any other DD waiver service.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional offices

Frequency of Verification:
Prior to contract approval; as needed based on service monitoring concerns

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:
Transportation

HCBS Taxonomy:

Category	Sub-Category
Category 1: 15 Non-Medical Transportation	**Sub-Category 1:** 15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
Transportation is reimbursable when necessary for an individual to access waiver and other community services, activities and resources specified by the service plan. Transportation under the waiver shall not supplant transportation provided to providers of medical services under the state plan as required by 42 CFR 431.53, nor shall it replace emergency medical transportation as defined at 42 CFR 440.170(a) and provided under the state plan. State plan transportation in Missouri is provided to medical services covered under the state plan, but not to waivered services, which are not covered under the state plan. Transportation is a cost effective and necessary part of the package of community services, which prevent institutionalization.

Regional offices must provide the transportation provider with information about any special needs of participants authorized for transportation services. A variety of modes of transportation may be provided, depending on the needs of the individual and availability of services. Alternatives to formal paid support will always be used whenever possible. A unit is one per month.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
State plan transportation under this waiver is limited to medical services covered in the state plan. State plan transportation does not cover transporting persons to waiver services, which are not covered under the state plan.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transportation Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Transportation Agency
Provider Qualifications
License *(specify):*
RSMo., Chapter 302, Drivers & Commercial Licensing
Certificate *(specify):*

Other Standard *(specify):*
DMH Contract
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional Offices
Frequency of Verification:
Prior to contract approval; as needed based on service monitoring concerns

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:

Division of DD Regional Offices (State Employees) and approved TCM Entities Employees

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):

(a) Background screening is required for all provider staff and volunteers who have contact with consumers. Background screenings are required for volunteers who are recruited as part of an agency's formal volunteer program. It does not apply to volunteers who assist individuals as a friend would by providing assistance with shopping, transportation, recreation, etc. Background screenings are also required for members of the provider's household who have contact with residents or consumers, except for minor children. (Section 630.170 RSMo, Title 9 Code of State Regulations 10-5.190 and Department Operating Regulation 6.510).

(b) An inquiry must be made for all new employees and volunteers with the Missouri DHSS to determine whether the new employee or volunteer is on the DSS or the DHSS disqualification list. An inquiry is also made with the DMH to determine whether the individual is on the DMH disqualification registry. A criminal background check with the Missouri State Highway Patrol (MSHP) is required. The criminal background check and inquiries are initiated prior to the employee or volunteer having contact with residents, clients, or patients. All new applicants for employment or volunteer positions involving contact with residents or clients must: 1) sign a consent form authorizing a criminal record review with the MSHP either directly through the patrol or through a private investigatory agency; 2) disclose his/her criminal history including any conviction or a plea of guilty to a misdemeanor or felony charges and any suspended imposition of sentence, any suspended execution of sentence, or any period of probation or parole; and 3) disclose if he/she is listed on the employee disqualification list of the DSS, DHSS, or DMH.

(c) Employers are responsible for requesting the background screenings. A single request is used and submitted to the state's Family Care Safety Registry (FCSR), operated by the DHSS. The FCSR has access to the criminal record system of the state Highway Patrol as well the abuse/neglect and employee disqualification lists/registries that are required. Employers responsible for requesting background screenings are any public or private residential facility, day program, or specialized service operated, licensed, certified, accredited, in possession of deemed status, or funded by the DMH or any mental health facility or mental health program in which people are admitted on a voluntary basis or are civilly detained. Pursuant to chapter 632 this background screen shall be done no later than two working days after hiring any person for a full-time, part-time, or temporary position that will have contact with clients, residents, or patients. The criminal history/background investigations are statewide.

(d) Each agency must develop policies and procedures regarding the implementation of this rule and the disposition of information provided by the criminal record review. Review of provider policies and procedures are part of a provider licensure/certification

site visit per 9 CSR 40-2.075.

The DMH licensure/certification process and Division of DD Provider Relations review process all look for evidence that background investigations are completed as required. The DMH licensure/certification process occurs every 2 years and Division of DD Provider Relations review process occurs every 3 years and both look for evidence that background investigations are completed as required.

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):

(a) The DMH maintains the Disqualification Registry which is a list of individuals disqualified from working with consumers receiving services from the department. Statutory authority is contained in RSMo 630.170. The DHSS also maintains an employee disqualification list.
(b) All new applicants for employment or volunteer positions involving contact with consumers or residents are checked against the DMH's Disqualification Register and the DHSS' Disqualification List.
(c) Surveys for licensing and certifying community residential facilities and day programs ensure these providers have records to support staff and volunteers have been properly screened. The DMH licensure/certification and Provider Relations review a sampling of employees during their review cycles which focus on new hires since the last review to ensure providers have a system to obtain screenings within the regulation parameters and are evaluating the results accurately. Local Regional Office quality enhancement staff or Department audit services staff review records while conducting other reviews or based on reports that screenings are not being completed.
(d) Employers are responsible for requesting the background screenings, including criminal background check and inquiries, no later than two working days after hiring. A single request is used and submitted to the state's FCSR, operated by the DHSS. The FCSR has access to the criminal record system of the state Highway Patrol as well the abuse/neglect and employee disqualification lists/registries that are required. Thereafter, the employer is responsible for ensuring that staff are free of disqualifying felonies or adverse actions by the Department of Health and Senior Services and DMH. Licensure/Certification survey process reviews background screenings every 2 years as initiated by the provider which includes reviewing the employee's personnel record.

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

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

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

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

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

☐ **Self-directed**

☐ **Agency-operated**

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

○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**

● **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

Personal assistant services shall not be provided by an individual's spouse, if the individual is a minor (under age 18) by a parent, or legal guardian. Personal assistant services may otherwise be provided to a person by a member(s) of his or her family when the person is not opposed to the family member providing the service and the service to be provided does not primarily benefit the family unit, is not a household task family members expect to share or do for one another when they live in the same household, and otherwise is above and beyond typical activities family members provide for another adult family member without a disability.

In case of a paid family member the service plan must reflect:
 The individual is not opposed to the family member providing services;
 The services to be provided are solely for the individual and not task household tasks expected to be shared with people live in family unit;
 The planning team determines the paid family member providing the service best meet the individual's needs;
 A family member will only be paid for the hours authorized in the service plan and at no time can these exceed 40 hours per week. Any support provided above this amount would be considered a natural support or the unpaid care that a family member would typically provide;
 Family members can be hired for personal assistant only.

Family is defined as: A family member is defined as a parent, step parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild.

Family members approved to provide personal assistant services may be employed by an agency or employed by the individual/guardian or designated representative using an approved FMS provider. If the person employs his/her own workers using an approved FMS provider, the family member serving as a paid personal assistant shall not also be the designated representative/common law employer.

Payments are only made for services that have been prior authorized and identified in the individual's service plan. There are edits in the system that only allow for prior authorized services to be billed and paid. The planning team determines whether the paid family member providing the service best meets the individual's needs. This support is documented in the ISP and regular service monitoring ensures the process is occurring.

○ **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 the Regional Office in the area where they plan to provide services. Regional Office contract staff determines if the provider meets provider qualifications by reviewing documentation that serves as proof of requirements such as licensing, certification, accreditation, training, appropriate staff, etc. If the provider is qualified, the Regional Office initiates a DMH Waiver contract with the provider and assists the provider with enrolling as a DD Medicaid Waiver provider through the Medicaid agency. All qualified, willing providers are assisted in enrolling as a waiver provider as provided in 42 CFR 431.51. The average time to enroll as a waiver provider is estimated to be 90-days.

Access to information regarding requirements and procedures for providers is available on the Division of DD website under "Information for Providers" and also available through the local regional office provider relations staff.

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:
The number and percent of licensed or certified providers with authorizations to bill through the waiver. (Number of providers with authorizations to bill waiver services that are licensed or certified divided by the number of providers with authorizations to bill waiver services)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers surveyed by Licensure and Certification within established timelines. (Number of providers surveyed by Licensure and Certification within established timelines, within the time period identified divided by Number of providers due for Licensure and Certification survey within the identified time period)

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers surveyed by Provider Relations within established timelines. (Number of providers surveyed by Provider Relations within established timelines, within the time period identified divided by Number of providers due for provider relations survey within the identified time period)

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

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

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

Data Aggregation and Analysis:

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

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 non-licensed and non-certified self-directed employees meeting waiver provider qualifications. (Number of self-directed employees meeting waiver provider qualifications within the sample within the identified quarter divided by Number of self-directed employees reviewed within the sample within the identified quarter.

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

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*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: Annually 1/3 sample which exceed .95 confidence level
	☐ **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 personnel records reviewed by Licensure and Certification during the time period identified meeting training requirements. (Number of personnel records reviewed by Licensure and Certification during the time period meeting training requirements divided by Number of personnel records reviewed by Licensure and Certification)

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% of all new employees and 20% of employees for continuing training.
	☐ **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 personnel records reviewed by Provider Relations during the time period identified meeting training requirements. (Number of personnel records reviewed by Provider Relations during the time period meeting training requirements divided by Number of personnel records reviewed by Provider Relations)

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sample will differ with provider services provided in accordance with Division Policy.
	☐ **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 staff records providing personal assistance(PA) and/or respite reviewed by Provider Relations(PR)during the time period identified meeting training requirements (Number of staff records providing PA and/or respite reviewed by PR during the time period meeting training requirements divided by number of staff records providing PA or respite reviewed by PR during the time period)

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% of providers in a 3 year cycle. Each provider has 3 employee records reviewed during the review for each authorized service.
	☐ **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.

(a1, a5, c1): New applicants who do not meet the initial provider enrollment qualifications are not enrolled as providers. Upon successful completion of the provider enrollment process, the provider relations staff notifies the DMH Licensure and Certification (L&C) Unit that the provider is ready to pursue their certification or license, if applicable for the services provided. The L&C Unit conducts a survey to determine if standards for those services are met and produces a written report within 30 business days of the site survey; if standards are met, L&C issues a license or a certificate. If the provider does not meet the standards, they must complete a plan of correction within 30 days of receipt of the written report. The L&C Unit then has 10 working days to accept or reject the plan of correction. Necessity for additional site visit(s) is determined by the type, scope and extent of the issues for improvement, and the L&C Unit, as well as the Provider Relations contact at the Regional Office, follows through on the process. Final determination of conformance to standards results in issuance of the license or certificate, or results in denial of license or certificate. If the license or certificate is denied, the contract is terminated. The Regional Office corrects any authorizations made in error as well as filing adjustments for any claims paid in error and reports the action to the Regional Office quality assurance staff in writing, describing how the error was corrected and any remedial training that was provided to staff.

(c-b2 and c-c2) Provider Relations staff at the Regional Office determine conformance with qualifications for contract purposes. Provider Relations conducts a review on an annual basis to assure the non-licensed/certified/accredited providers are in compliance with contract requirements.

Providers who do not maintain qualifications are dis-enrolled as providers for waiver services. The Regional Office corrects any authorizations made in error as well as filing adjustments for any claims paid in error and reports the action to the Regional Office quality enhancement staff in writing, describing how the error was corrected and any remedial training that was provided to staff. Individuals would be offered other waiver provider options and choices to select a new waiver provider.

(b1) In addition to targeted training all self-directed employees must have background checks completed and be registered with the FCSR before they can be paid for services. If it is determined a worker did not have a background check completed prior to the worker beginning, the FMS contractor is notified within 10 days of discovery by Regional Office management staff that an error has occurred since the contractor is responsible for background checks. The contractor must respond in writing with 30 days to the Regional Office describing how the error has been corrected. Case management staff will assure the worker does not provide additional services until the check is completed satisfactorily. Administration staff will take action to adjust authorizations made in error and any claims paid in error.

(c1): The L&C Unit conducts a survey to determine if standards are met and produces a written report within 30 business days of the site survey; if standards are met, L&C issues a license or a certificate. If the provider does not meet the standards, they must complete a plan of correction within 30 days of receipt of the written report. The L&C Unit then has 10 working days to accept or reject the plan of correction. Necessity for additional site visit(s) is determined by the type, scope and extent of the issues for improvement, and the L&C Unit, as well as the Provider Relations contact at the Regional Office, follows through on the process. Final determination of conformance to standards results in issuance of the license or certificate, or results in denial of license or certificate. If the license or certificate is denied, the contract is terminated. The Regional Office corrects any authorizations made in error as well as filing adjustments for any claims paid in error and reports the action to the Regional Office quality assurance staff in writing, describing how the error was corrected and any remedial training that was provided to staff.

Providers accredited by CARF International or Council for Quality and Leadership (CQL) are deemed certified, as outlined in Missouri Code of State Regulation. These accredited providers submit a copy of their most recent accreditation survey and the statement of accreditation to the Division of DD, to verify that the accreditation status is current and to determine what areas of improvement are noted. If an improvement plan is required by the accrediting body, that correspondence is also submitted to the Division. The Division Standards and Accreditation Coordinator tracks to assure that these reports are submitted and reviewed; if the current status is not on file, the Coordinator contacts the Provider Relations staff at the Regional Office to assist in obtaining the required documentation.

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:
Person Centered Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - ☐ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - ☐ **Licensed physician (M.D. or D.O)**
   - ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
   - ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
     Specify qualifications:
   - ☐ **Social Worker**
     Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

The Division has procedures for support coordinators to follow to ensure choice in providers, services, institutional care, and service delivery options are reviewed with the participant and legally authorized representative annually. The Division rules for TCM entities also require the support coordinator to review choice, plan for services, risks, and one's goals without any undue influence from other providers or parties.

The TCM entity may provide waiver services, but NOT to an individual for whom the agency provides support coordination. System changes are in transition, and the state will complete the system changes by December 31, 2018, in accordance with the timeline separately submitted to CMS.

During the annual plan meeting, or as the situation arises during support monitoring, the support coordinator will discuss options with the individual to avoid conflicted arrangements. If a TCM entity is providing both TCM and direct services to the same individual, the individual will have to choose that provider for either TCM services or direct services. The support coordinator will educate and inform the individual on choices of TCM entities and waiver providers to prevent conflicted arrangements.

One of the Division's integrated quality functions is the targeted case management reviews conducted by the technical assistance coordinator (TCM TAC) reviews, with a sampling which includes 100% sampling of all Support Coordinators:
a. Verification that the conflict of interest statement is included in the support plan; and
b. Interaction/contact with consumers and/or their guardians to verify effectiveness of the procedures.

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.

The planning team responsible for the development of the ISP should be led by the individual, where possible. The individual's representative, family or guardian, and any other individuals they choose should have a participatory role. When individuals are children under the age of 18 living with their family, the parent(s) choose who they want to attend as a member of the planning team, and the parent(s) must participate in the meeting.

All support coordinators must be trained on the Division of DD Person Centered Planning Guidelines prior to facilitating an ISP. The guidelines describe person-centered planning as a process that is directed by the individual (waiver participant),with assistance as needed from a representative (support coordinator) and reinforces the responsibility of the support coordinator to ensure that waiver participants are full partners in the planning process.

A component of support coordinator’s initial training is on the support planning process. The Person Centered Planning guide is a component of the training which emphasizes the support coordinator role to encourage the participant/ family or guardian to actively engage in and direct the service plan development through the person-centered planning process, which includes:

• Individuals choosing people to participate in the process.
• Providing necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
• Is timely and occurs at times and locations of convenience to the individual.

• Reflecting cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
• Strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
• Offering informed choices to the individual regarding the services and supports they receive and from whom.
• Including a method for the individual to request updates to the plan as needed.

The guidelines are available to individuals and their families on the Division of DD's web page. The support plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

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 individual support plan is developed through a person-centered planning process. The individual will lead the planning process where possible. The planning team includes the individual and his or her representatives, family or guardian and other people chosen by the individual. If the individual is a minor, or has been judged incompetent, the family or guardian must attend. The team includes providers selected by the individual. Other professionals involved with the individual may be included as applicable and at the individual's invitation. The individual leads the process and the Support Coordinator ensures the process is followed by scheduling meetings with the individual and ensuring these meetings are timely and occur at a time and location of convenience for the individual. The SC documents that the individual was present at the meeting and how the individual contributed. The plan is usually facilitated by a support coordinator employed by a Division of DD Regional Office or an approved TCM Entity. If the person so chooses, another facilitator may be used, but the support coordinator will participate in the planning.

No later than 30 days from the date of acceptance into the waiver program the planning team develops a support plan with the individual. Initial plans must contain at least an accurate beginning profile of the person. The profile needs to reflect what the person sees as important in relationships, things to do, places to be, rituals and routines, a description of immediate needs, especially those that are important to the person's quality of life including health and safety and information about what supports and/or services are required to meet the person's needs. The plan facilitator must make sure that each item in the action plan has enough detail and/or examples so that someone new in the person's life understands what is meant and how to support the person. If the initial plan is not comprehensive, it can cover no more than 60 days, during which time a more comprehensive plan must be finalized.

The support plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. The plan must be distributed to the individual and other people involved in the plan.

(b) The plan is based on the support coordinator's functional assessment of the individual and all other assessments that are pertinent. Missouri uses the MOCABI functional assessment tool for Adults and Vineland or other age appropriate tools for children. Assessments include observations and information gathered from the members of the team.
The functional assessment determines how the individual wants to live, the individual's routines, what works for the individual and what does not. It also assesses what the individual wants to learn and how the individual learns best. It measures how independently the individual functions and what interferes with what the individual wants, and it suggests ways the individual's needs and wants can be met.

(c) Upon being determined eligible for Division of DD services, each individual and/or legal representative, or guardian receives information regarding available services and programs, including information about the waiver. After needs are identified through the planning process, the support coordinator reviews this information once more and together with the individual and the interdisciplinary team specific services and supports are identified to meet the participant's needs.

(d) ISPs must be written in accordance with Division of DD's ISP Guide and Missouri Quality Outcomes. The ISP Guide include a description of mandatory plan components. Mandatory components include: demographics; health and safety, who and what are important to the person; individual's strengths and preferences; what staff need to know and do to provide support; requirements of the family of a minor child or their guardian, how the person communicates and issues to be resolved. Setting options are identified and documented in the plan, based on the individual's needs, preferences, and, for residential settings, resources available for room and board. The plan reflects the setting in which the individual resides was chosen by the individual.

The plan specifies all the services and supports that are needed and who is to provide them, to enable the individual to live the way the individual wants to live and learn what the individual wants to learn. These methods may include teaching, which does not have to be behavioral. Learning can be incidental as long as it is planned. Providing supports or making adaptations to the environment may be part of the plan. The plan specifies any limitations the planning team foresees in being able to support the individual in achieving these desires. Such limitations can be financial, temporal and/or can relate to health and safety.

(e) ISPs address all supports and services an individual is to receive. This includes services provided through the waiver, other state plan services and natural supports. For each need that is expressed, the plan must describe what support or service is being provided to meet that need. Providers selected by the individual are responsible for providing services in accordance with the plan. The support coordinator is responsible for coordinating services provided by other agencies or individuals and monitoring the provision of services during routine monitoring visits.

(f) Each outcome on the plan must be accompanied by information regarding the person(s) responsible for assuring progress. Timelines for completion of each outcome is specified. Support coordinators monitor this progress during plan review visits.

(g) ISPs are subject to continuous revision. At a minimum, the entire team performs a formal review at least annually. The support coordinator maintains at least quarterly contact with each individual, their family or guardian with at least an annual face to face contact for the individual who resides in their natural home setting. Monthly face to face contact is required for individuals in residential placement. During quarterly contact, the support coordinator monitors the individual's health and welfare. Progress notes document the contact and whether the outcomes stated in the plan are occurring.

Support coordinators are responsible for reviewing the provider's notes at least quarterly, and for observing and documenting any problems, discrepancies, dramatic changes or other occurrences which indicate a need for renewed assessment. The support coordinator's review of the provider notes includes making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk. During monitoring and record reviews, the support coordinator determines if the support plan continues to meet the needs of the individual and with the approval of and input from the individual, their family or guardian, and makes any necessary revisions.

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.

The ISP Guide require that support plans identify risk to individuals to assure their health and welfare. When the individual will be learning or doing something that involves increased risk, the plan or action plan will describe: 1) Action taken to assure the person is making an informed choice, including a description of what has been done to assure that the person clearly understands what risks are involved and possible consequences; 2) What the individual needs to know and the skills and supports that are necessary for the individual to achieve his/her goal; 3) How supports will be provided, skills that will be taught and by whom; 4) What others in the community need to know and do to provide support to the individual; and 5) What follow-up and monitoring will occur.

A Health Inventory assessment is completed on an annual basis for all individuals in waiver residential placement. The inventory must also be completed on individuals who experience a significant change in physical or mental health status. The support coordinator completes the electronic health inventory. Once completed, the designated Regional Quality Enhancement (QE) RN is notified and determines based upon the health inventory score whether a QE nurse review is required. When a QE nurse review is conducted, findings are electronically communicated to the support coordinator for remediation. All health indicators identified on the Health Inventory are considered significant and are to be discussed along with necessary supports in the appropriate section of the support plan. The Support Coordinator is responsible for inclusion of health information in the support plan and consults with the QE RN with any questions.

Providers and lead agencies are responsible for back-up plans and this is part of the service that they provide. There are back-up plans for everyone and the agency should inform individuals about what the back-up plan is and what is contained in the back-up plan. The support coordinator is responsible for ensuring that all back-up plans associated with the individual are incorporated into the individual's service plan.

Individuals who self-directed services are required to include a back up plan in their support plan. Back up plans include a description of the risks faced when emergencies, such as lack of staff arises. The back up plan also identifies what must be done to prevent risks to health and safety; how people should respond when an emergency occurs; and who should be contacted and when. Back up plans must list at least 2 individuals who will provide support when regular staff is not available.

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.

When more than one provider of service is enrolled as a waiver provider, the individual or legal guardian is given a choice among eligible providers. The support coordinator educates and informs individuals regarding eligible providers of services to the individual or guardian during the annual planning process, and at any other time as needed. The Medicaid Waiver, Provider, and Services Choice Statement is used in conjunction with educating and informing individuals of eligible providers for documentation of provider choice. Documentation of education and choice of providers must be included in the annual plan. Attached to the choice statement is the list of eligible providers for the given service. The Regional Office or TCM Entity that is providing support coordination is responsible for ensuring individual choice of provider statements are obtained and maintained in the individual's case record.

The Division of DD makes every effort to build provider capacity in rural areas. Each regional office has Provider Relations staff designated to work with provider development. If there are limited providers available for a chosen service the Division will work closely with the individual to identify other providers that would be willing to provide the needed service in the area of the state where the individual resides.

Accessible information on choice of qualified providers is provided by the support coordinator during the planning team meetings. The planning team utilizes the ISP Guide which emphasizes the support coordinator role to provide accessible information on the choice of qualified providers, which includes:

• Providing necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
• Reflecting cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
• Offering informed choices to the individual regarding the services and supports they receive and from whom.

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):

Annually, the MHD selects a statistically valid sample (95% confidence level and a plus or minus 5% margin of error rate) of waiver support plans for review. This review by staff from the State Medicaid Agency ensures individuals receiving waivered services had a support plan in effect for the period of time services were provided. The review process also ensures that the need for services that were provided was documented in the support plan, and that all service needs in the support plan were properly authorized prior to service delivery.

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:

Approved Targeted Case Management Entities that provide support coordination, including support plan development, maintain the support plans of participants for whom they coordinate services.

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.) Monitoring the implementation of the support plan and the participant health and welfare is the responsibility of the planning team (Code of State Regulation 9 CSR 45-3.010). This process is facilitated by the support coordinator employed by a Division of DD Regional Office or an approved TCM Entity, and designated management staff from the community provider.

b.) & c.) Support plans and participant health and welfare are monitored and follow-up action is taken through the following processes and frequencies:

1.) Support coordinators monitor health, fiscal issues, services and staff, environment and safety, and individual rights during monitoring visits with the participant, per the Support Monitoring Policy and Implementation Guidelines . At a minimum of quarterly, the support coordinator monitors the health and welfare of the participant. These quarterly reviews include a review of the support plan to ensure service needs identified in the plan are being met. The review is accomplished by reading provider progress notes, contact with the individual and/or responsible party and through observation. If non-waiver service needs are identified in the support plan, the support coordinator determines the person or entity identified in the support plan as responsible for helping the individual access the service(s) and determines if services are being received as planned. Non-waiver services may include health services the individual accesses through State plan Medicaid services. Review of the support plan and the person's health and safety includes a review of the backup plan for participants who self direct. Monitoring considers whether the backup plan has been implemented, and if so, whether the plan sufficiently met the individual's needs and whether all persons and entities named as part of the backup plan are still available to assist. If changes are needed to the backup plan, the support plan will be updated accordingly. Results are documented in a quarterly review note or a case note when the monitoring was not part of the quarterly review process. Back-up plans for participants served by agencies are required dependent upon an individual's assessed needs. When the needs are identified, TCM TAC reviews the back-up plan.

When an issue or concern is discovered around an individual's health, safety/environment, rights, money, services, or backup plan, the support coordinator supervisor, individual's guardian and/or the provider's designated management staff are notified. If a concern is not an immediate risk to the person's health or welfare and cannot be quickly resolved then the support coordinator indicates the type of action plan that will be taken to address the issue. Concerns around the sufficiency of the back-up plan shall be immediately resolved which will include a revised service plan. All issues/concerns identified from support monitoring and ISP Review processes and action taken are entered in the Division's APTS for trending and tracking purposes. Support coordinators are employed by the state or by TCM entities. Both are responsible for reporting information in the State's APTS and for maintaining case notes.

If monitoring discovers there is a lack of progress on achieving the outcomes identified in the support plan, the support coordinator documents this and works with the individual and the interdisciplinary team to revise and amend the plan as needed. Support plan revisions can only be implemented with the approval of the participant's parent or guardian.

2.) The Support Plan Review process ensures the individual planning process is person-centered and leads to quality outcomes for individuals. The process also evaluates the effectiveness of support services in meeting individual needs, identifies support service strengths, and areas needing improvement. Each person supported by the Division must have a service plan that meets the minimum criteria described in the Division of DD Individual Support Plan Guide.

Support plans must be reviewed and updated if necessary on or at least a quarterly basis. The review and update must also occur when:
a) the person or the person’s guardian requests that information be changed or added;
b) others invited by the person to participate in his/her support plan provide additional information;
c) needs for supports and services are not being adequately addressed;
d) a back-up plan failed or needs to be revised due to a change in the availability of persons named or entities named; or
e) the need for support and service changes.

3) The MHD reviews a statistically valid random sample(statistically valid sample 95% confidence level and a plus or minus 5% margin of error rate) of waiver participant records annually. The compliance review includes looking at ISPs. Information reviewed may include the support plan, LOC evaluation, annual re-determination of the LOC, assessments used to determine the LOC, service reviews completed by support coordinators, provider monthly reviews of the support plan, provider choice statements completed by the individual, and waiver choice statements completed by the individual. The review by the MHD ensures all service needs identified in the support plan are being met regardless of the funding source for support. If there is no evidence that a need in a person's support plan

is being met, this is a review finding which will be referred back to the regional office or county entity. Depending on the urgency of ensuring the need is met, a phone call may be placed or the request for corrective action will be provided in writing. Division of DD staff is responsible for ensuring that corrective action is taken and for reporting the action to the MHD.

4.) A random review (statistically valid sample of 95% confidence level and a plus or minus 5% margin of error rate) of ISPs is completed on a quarterly basis. This includes both regional office, as well as contracted TCM agencies which provide case management. The review is conducted by Division of DD staff on a statistically valid sample of waiver participants to ensure adherence to CMS waiver and Division of DD requirements.

5.) Issues and remediation identified through monitoring, are entered into the Division of DD's APTS. Reports are shared with Medicaid Agency annually, upon request, or when critical events related to health and safety occur.

d.) TCM TAC ISP Review monitoring includes ensuring the individual has free choice of provider for all waiver services. Initially a form is completed to reflect choice of provider. If a new service is initiated, or a new provider is identified, the support coordinator would complete a new form to verify provider choice. Quarterly a random sample of ISPs and associated documentation are reviewed through the ISP review.

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:*

The Division has procedures for support coordinators to follow to ensure choice in providers, services, institutional care, and service delivery options are reviewed with the participant and legally authorized representative annually. The Division rules for TCM entities also require the support coordinator to review choice, plan for services, risks, and one's goals without any undue influence from other providers or parties.

The TCM entity may provide waiver services, but NOT to an individual for whom the agency provides support coordination. System changes are in transition, and the state will complete the system changes by December 31, 2018, in accordance with the timeline separately submitted to CMS.

During the annual plan meeting, or as the situation arises during support monitoring, the support coordinator will discuss options with the individual to avoid conflicted arrangements. If a TCM entity is providing both TCM and direct services to the same individual, the individual will have to choose that provider for either TCM services or direct services. The support coordinator will educate and inform the individual on choices of TCM entities and waiver providers to prevent conflicted arrangements.

The Division of DD has the following safeguards to ensure monitoring is conducted in the best interests of the participant:

1)Individuals have the option to request a different support coordinator from the same case management entity they are assigned.

2)Support Monitoring Policy and Implementation Guidelines, sets monitoring standards that all support coordinators must follow in reviewing environment/safety, health, services and staff, money and rights.

3)Support coordinator entities are included in support coordination and waiver related training conducted by regional offices.

4)Division of DD regional office TACs review a sample of support coordination log activities on an annual basis for each Support Coordinator. Findings are entered into the Division of DD’s APTS for tracking and trending purposes. Some of the log notes in the sample would include results of monitoring activities and any corrective action taken.

5)Monitoring activities are subject to the review of the Division of DD, the operating agency, and the State Medicaid Agency, the MHD. Annually the MHD randomly selects waiver participants for a compliance review. The review includes reviewing support plans and quarterly reviews from monitoring. Participants served by entities that provide both waiver services and monitor the services are subject to this review.

6)Division of DD regional office TACs review the performance of entities that provide support coordination. Corrective action is taken if there is evidence a participant has health and welfare issues that have not been met or is dissatisfied with support coordination.

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 support plans in which services and supports are aligned with assessed needs. (Number of support plans indicating supports and services are aligned with assessed needs reviewed within the identified quarter divided by the total number of support plans reviewed in the identified quarter)

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Representative sample .95 Confidence Interval that is stratified by region
	☐ **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 support plans addressing identified health risks. (Number of support plans addressing identified health risks as reviewed within the identified quarter divided by the total number of support plans reviewed in the identified quarter)

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Representative sample .95 Confidence Interval that is stratified by region
	☐ **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 Support Plans addressing participants' desired outcomes. (Number of Support Plans addressing participants' desired outcomes divided by the total number of Support Plans reviewed in the identified quarter)

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

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

	☐ **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 support plans addressing participants' safety risks. (Number of support plans addressing participants' safety risks divided by the total number of support plans reviewed in the identified quarter.)

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

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

☐ **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 plans are reviewed in accordance with the State's policy for monitoring. (number of support plans reviewed divided by the number of support plans required to be reviewed in the identified timeframe.)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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: Representative sample .95 Confidence interval that is stratified by region.
	☐ **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 support plans reviewed containing a back-up plan when identified as needed. (Number of support plans for individuals containing a back-up plan when identified as needed divided by the number of support plans for individuals with an identified need for a back-up plan.)

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

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

		Confidence Interval = .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 plans in which the person/person's guardian signed and dated the plan prior to implementation. (Number of support plans where the person/person's guardian signed and dated prior to the implementation date divided by the number of plans reviewed within the identified quarter)

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

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

		.95 confidence level
☐ **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 plans that describe what people need to know or do in order to support the person(Number of plans within the sample describing what people need to know or do in order to support the person divided by the number of plans reviewed within the identified quarter.)

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Representative sample .95 Confidence Interval that is stratified by region
	☐ **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 support plans updated/revised at least annually. (Number of support plans updated/revised at least annually divided by the number of support plans reviewed within the identified quarter)

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Representative sample.95 Confidence Interval that is stratified by region
	☐ **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 Support plans that were updated to reflect identified changes in need. (Number of support plans reflecting identified changes in need that were updated to reflect those changes divided by the number of support plans with an identified need for change reviewed within the identified quarter)

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

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Representative sample.95 Confidence Interval that is stratified by region
	☐ **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 waiver participants who receive services in the type, amount, frequency, scope and duration authorized in their support plan (Number and percent of waiver participants who receive services as authorized in their support plan divided by the number of waiver participants with authorized services within the identified time frame)

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

☐ **Other** Specify:

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 completed and signed Medicaid Waiver, Provider, and Services Choice Statements specifying choice was offered between Waiver services and institutional care. (Number of completed and signed Medicaid Waiver, Provider, and Services Choice Statements confirming choice of waiver participation divided by the number of records reviewed within the identified timeframe)

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = .95 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 completed and signed Medicaid Waiver, Provider, and Services Choice Statements indicating choice was offered between providers. (Number of completed and signed Medicaid Waiver, Provider, and Services Choice Statements indicating choice was offered between providers divided by the number of records reviewed within the identified timeframe)

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and	**Frequency of data aggregation and analysis**

analysis *(check each that applies):*	*(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 completed and signed Medicaid Waiver, Provider, and Services Choice Statements indicating choice was offered between waiver services. (Number of completed and signed Medicaid Waiver, Provider, and Services Choice Statements indicating choice was offered between waiver services divided by the number of records reviewed within the identified timeframe)

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

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

D-a 1, 2, 3, and 4 and D-b 2, 3, and 4, D-c1 and 2 Designated Regional Office staff review a sampling of ISP support plans every quarter and communicate to support coordinators regarding any findings requiring remediation and track to ensure remediation occurs.

(a) If a plan does not meet criteria set forth in the ISP Guide, remediation may include training as needed. The director of a TCM entity is responsible for determining systems enhancements. If personnel actions are needed for individual support coordinators, including, but not limited to, training or re-training, verbal or written warnings, suspension or termination.

D-d 1 Assigned Support Coordinators as a component of their ongoing service monitoring enter findings requiring remediation into the division's APTS which is monitored by local QE to ensure remediation timelines are met.

D-b 1 Designated state level QE staff monitor on a quarterly basis established timelines to assure process is met. Any findings for remediation are followed up locally with applicable staff.

D-e 1, 2, and 3 Designated Regional Office staff review a sampling of Medicaid Waiver, Provider, and Services Choice Statements every quarter and communicate to support coordinators regarding any findings requiring remediation and track to ensure remediation occurs.

ii. Remediation Data Aggregation

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

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

	☐ **Other** Specify:

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

- ◉ **No**
- ○ **Yes**
  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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.

a) Expectations for Person Centered Planning, reflect the values outlined in the Missouri Quality Outcomes. Those outcomes acknowledge principles that people have control of their daily lives, and that plans should reflect how they want to live their life. Person-centered planning is the foundation in which people can determine the direction of their lives, identify the supports they will need, and how those supports should be delivered to assist them to move in their personally identified direction. The planning process is under the direction of the individual or a representative of their choice. The process identifies needs and how those will be met by both paid and unpaid supports, who will provide the supports, and how supports will be provided within agreed upon parameters.

b) Individuals/guardians or designated representatives may choose to self-direct Personal Assistant services and Community Specialist services and be the employer though a Vendor/Fiscal Agent (VFA) FMS Services. All Individuals have a support coordinator trained to facilitate the person centered planning process, but they may also use community specialist or support broker for information and assistance in defining goals, needs and preference, identifying and accessing services, supports and resources as part of the person centered planning process which is then gathered by the support coordinator for the Support Plan. Individuals/guardians or designated representatives direct how their individualized budget is to be expended to exercise control of their allocated resources. They have the option to have a support broker to provide information and assistance in order to help in recruiting, hiring, and supervising staff. The individual/guardian or designated representative is the common law employer with the assistance of a VFA FMS who will perform payroll, taxes, broker workers compensation, etc.

c) Resources available to support individuals who direct their services include the ability of the individual/guardian or designated

representative to facilitate the support plan with the assistance of the support coordinator. The individual/guardian or designated representative recruits, hires and self-directs employees and performs other employer supervisory duties. Individuals/guardians or designated representatives may be authorized for a support broker to provide assistance. FMS are required for individuals who self-direct. The financial management contractor provides the individual or representative with technical assistance in getting employees set-up for payroll services and in tracking expenditures. Support coordinators are responsible for monitoring: health and safety, ensuring individuals stay within budgeted allocations, and required documentation is created and maintained. Additionally the support coordinator is responsible in informing individuals of the option to self-direct. A support broker is an option for individuals who need additional information and assistance in managing and directing their employees. The self-directed supports coordinator is a state employee who is available to provide technical assistance, creating system enhancements, tracking and trending issues, and provide oversight of the option to self-direct.

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

Only Personal Assistant and Community Specialist may be self-directed. For individuals who do not choose to self-direct, waiver services are available through MO HealthNet enrolled waiver provider agencies. Only individuals who live in their own private residence or the home of a family member may self-direct.

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.

a) Individual/guardians or designated representatives learn about self directed support options from the support coordinator during the person centered planning process when needs are identified and ways of supporting the needs are discussed. During the person centered planning process, individuals have the opportunity to weigh the pros and cons of participant direction. Self directed supports is listed on the Medicaid Waiver, Provider, and Services Choice Statement. Individual/guardians or designated representatives also often learn about self directed supports from other individuals or families who are directing their own services. Information on self-directed services is included in the waiver manual which is available to the public. The waiver manual and the Individual Handbook on self-directed support is also available on the DMH/Division of DD web-site. The information assists support coordinators in describing the benefits and processes for self-direction and provides written material for individuals and/or legal representatives on the specifics. Regional offices have a self-directed coordinator that is available to provide technical assistance and guidance to support coordinator and other stakeholders. As part of the person centered planning process, the specialized needs of the individual are discussed with the planning team to identify any potential liabilities or risks the individual may face, and to determine a plan for how each potential liability and risk will be addressed.

b) DD TCM Entities providing support coordination are responsible for furnishing information on self-direct supports options.

c) DD TCM Entity support coordinators are trained on self-directed supports options. If the support coordinator hasn't been through the training, regional office self-directed coordinators may be asked to assist in providing information to the individual with the support coordinator. This information is presented during the person centered planning process when individual needs are identified and ways of supporting the needs are discussed, anytime the individual is dissatisfied with provider based services, or upon inquiry by the participant/guardian or designated representative.

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.**
- ☑ **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:

An Individual's Right to Have a Designated Representative

This waiver serves participants age 17 or younger, and all will have a designated representative when choosing self-direction. The designated representative will assist the individual in their responsibilities as the managing employer of their employee (s), in accordance with the guiding principles of self-determination. If a representative has been designated by a court, the legal guardian will identify themselves or another person as the representative.

A designated representative must:

1. Direct and control the employees' day to day activities and outcomes;
2. Ensure, as much as possible, that decisions made would be those of the individual in the absence of their disability;
3. Accommodate the individual, to the extent necessary, so that they can participate as fully as possible in all decisions that affect them; accommodations must include, but not be limited to, communication devices, interpreters, and physical assistance;
4. Give due consideration to all information including the recommendations of other interested and involved parties; and
5. Embody the guiding principles of Self-Determination;
6. Not be paid to provide any supports to the individual.

The following people can be designated as a representative, as available and willing:
-A spouse (unless a formal legal action for divorce is pending)

-An adult child of an individual
-A parent
-An adult brother or sister
-Another adult relative of the individual
-Other representative. If the individual wants a representative but is unable to identify one of the above, the individual along with their support coordinator, and planning team, may identify an appropriate representative. The 'other representative' must be an adult who can demonstrate a history of knowledge of the individual's preferences, values, needs, etc. The individual and his or her planning team is responsible to ensure that the selected representative is able to perform all the employer-related responsibilities and complies with requirements associated with representing one individual in directing services and supports.

The planning team and Fiscal Management Service Provider (FMSP) must recognize the participant's representative as a decision-maker and provide the representative with all of the information, training, and support that would typically be provided to a participant who is self-directing. The representative must be informed of the rights and responsibilities of being a representative. Once fully informed the representative must sign an agreement which must be given to the representative and maintained in the participant's record. The agreement must list the roles and responsibilities of the representative, the roles and responsibilities of the FMSP, must include that the representative accepts the roles and responsibilities of this function; and state that the representative will abide by the FMSP policies and procedures. The designated representative must function in the best interest of the participant and may not also be paid to provide services to the participant. The individual or guardian can at any time revoke the agreement with the designated representative.

The non-legal representative signs an agreement which states they will act in the best interest of the individual and will comply with the program requirements. The choice of non-legal representative is reviewed by the planning team and documented in the ISP. Additionally, the support coordinator completes quarterly service monitoring as well as a quarterly provider reviews to ensure program rules are followed.

Service Monitoring takes place with each waiver participant as outlined in Appendix D-2. The monitoring process can lead to identifying issues with the representative not acting in the best interest of the waiver 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
Community Specialist	☑	☑
Personal Assistant	☑	☑

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:

- ◉ **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:

The Division of DD has a statewide contract with a Vendor Fiscal/ Employer Agent (VF/EA) FMS provider for payroll services including, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance. A single VF/EA FMS contractor is responsible for payroll functions. This contractor is also responsible for verifying the citizenship status and background screenings of new workers and making available expenditure reports to individual. Reimbursement for FMS is an administrative service and not fee for service. The provider is not a governmental entity. VF/EA is responsible for maintaining a separate account for each participant's budget, tracking and reporting disbursements and balances of participant funds, and processing and paying invoices for services approved in the service plan.

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

The Division pays the VF/EA FMS contractor for services provided with general revenue and seeks reimbursement through the MO HealthNet program as an administrative expense. FMS are provided through a single statewide contract that is re-bid every 3 years. The contractor is a private company. The contractor has a specific rate for each new worker added, each check written etc. (by transaction). The contractor is paid for these services with general revenue and records of payments will be submitted for 50% reimbursement as administrative service in compliance with 45 CFR 74. FMS are not reimbursed based on a percentage of the total dollar volume of transactions it processes. The FMS sends a detailed invoice to the Division of DD monthly for the actual cost.

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:

- ☑ **Assist participant in verifying support 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**
- ☑ **Other**

Specify:

The FMS contractor is available for technical support to the participant/guardian or designated representative in completing paperwork to set up as an employer, completing paperwork for each new worker/employee, and facilitates background checks for all new workers. The FMS maintains evidence of employee qualifications and service documentation on behalf of the individual and family. The FMS contractor maintains an internet web-portal where worked time can be recorded. The participant/guardian or designated representative, the employees and staff at Regional Offices, and support coordinator have access to the secure web-based system to view payment information. Individual/guardians or designated representatives can view total amounts authorized, payments made to workers, and balances. Workers can view current payroll information as well as YTD. Regional office staff and support coordination staff can also view authorized amounts, payments, and balances.

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:

- [ ] **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**
- [x] **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.

Oversight of the FMS entities:
a)Individual Directed Services are prior-authorized by the local Regional Office on a yearly basis based on the support plan. Dollars authorizations are sent to the FMSP by Central Office on a daily basis (M-F) based on the regional office authorizations. Employees input delivered services by entering time through the internet on the FMSP's web-portal or faxing paper timesheets. Regional Office staff has access to review information that is input. Individuals/designated representatives also have access to the system to approve services and to review their account of authorized and delivered services/dollars. The FMS provider pays workers by direct deposit or a manual check, and calculates, files reports and pays taxes that are due. Employee pay stubs reflecting withholdings from gross payroll are available on-line or sent by regular mail, if requested, to the employee each pay period.

The FMSP maintains a web portal for the employer. The web portal generates live time reports per payroll expenditures, which itemizes reporting of wages for each employee, total payments, total dollar amounts paid on behalf of each participant. For individuals/designated representatives who do not have internet access reports are sent monthly by mail. These reports are made available to Regional Officesand support coordinators. Additionally the FMSP's processes and systems have quality controls that ensure accurate and appropriate billing. These include system "flags" that identify over-authorizations, duplicate services, duplicate individuals and correct codes/authorizations. This ensures that units billed will not exceed state Medicaid maximums, duplicate billing for same services, and employees only enter billing for authorized services.

b) Participant services are monitored by the TCM Entity support coordinator. If concern is noted, the quality enhancement leadership team is asked to conduct a further review.

DMH Central Office also monitors the FMSP to ensure contracted activities in support of self-directed services are completed in an Individual centered, timely, and accurate manner. The FMSP also follows their own internal quality assurance plan to meet accounting controls and performance standards including communications, payroll processing, and reporting. Additionally, the FMSP arranges for an annual external CPA agency audit to insure financial internal controls are followed. This report is shared with Individual for whom the FMSP is providing contracted services.

c) Monitoring by the support coordinator is quarterly, unless there is reason to monitor more frequently. The FMS contractor, as the agent for the participant/guardian or designated representative, receives all correspondence from federal, state and local employment-related tax and insurance entities and continuously monitors for problems. The FMSP shall make available all records, books and other documents related to the contract to DMH, its designee, and/or the Missouri State Auditor in an acceptable format, at all reasonable times during the contract period and for three years after the contract termination. The Missouri's State Auditor's Office routinely reviews all programs for problems when auditing each Division Regional Office and Central Office operations.

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
Specialized Medical Equipment and Supplies (Adaptive Equipment)	☐
Community Specialist	☐
Crisis Intervention	☐
Assistive Technology	☐
Out of Home Respite	☐
Transportation	☐
In Home Respite	☐
Individualized Skill Development	☐
Day Habilitation	☐
Environmental Accessibility Adaptations-Home/Vehicle Modification	☐
Person Centered Strategies Consultation	☐
Support Broker	☑
Applied Behavior Analysis	☐
Community Integration	☐
Personal Assistant	☐

☐ **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:

If an individual voluntarily requests to terminate individual direction in order to receive services through an agency, the support coordinator will work with the individual or legal representative to select a provider agency and transition services to the agency model by changing prior authorizations based on the individual's needs. The support coordinator and other staff with the regional office will make every effort for the transition to be smooth and to ensure the individual is not without services during the transition. If SDS is terminated, the same level of services will be offered to the individual through a traditional agency model.

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.

If the planning team determines the health and safety of the individual is at risk, the option of self-directing may be terminated. The option of self-directing may also be terminated if there are concerns regarding the participant/guardian or designated representative's willingness to ensure employee records are accurately kept, or if the participant/guardian or designated representative is unwilling to supervise employees to receive services according to the plan, or unwilling to use adequate supports or unwilling to stay within the budget allocation, or the participant/guardian or designated representative has been the subject of a Medicaid audit resulting in sanctions for false or fraudulent claims under 13 CSR 70-3.030.

Before terminating self-direction options, the support coordinator and other appropriate staff will first counsel the individual or legal representative to assist the participant or legal representative in understanding the issues, let the participant or legal representative know what corrective action is needed, and offer assistance in making changes. If the individual/guardian or designated representative refuses to cooperate, the option of self-directing may be terminated. However, the same level of services would be offered to the individual through an agency model.

During the involuntary termination process, the support coordinator and planning team helps the individual transition to an agency model of their choice. If it is an immediate health and safety issue, the support coordinator and planning team would arrange for immediate temporary supports until a long-term agency is chosen by the individual.

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		176
Year 2		193
Year 3		211
Year 4		232
Year 5		254

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**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Division of DD regional offices pay the costs. The FMSP obtains the background checks.

☑ **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.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☑ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

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:*

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*:

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

Specify:

The individual and/or designated representative approve self-directed employee electronic timesheets for services rendered by use of the FMSP web portal, or by providing signatures on paper timesheets.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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.

For an individual who is self-directing their services, the planning team determines needs based on gathered assessments, such as the Support Intensity Scale. The participant and their planning team identify how they best meet the assessed needs. The team identifies how these needs can be met through informal supports and other sources. Any needs that cannot be met through these means will constitute the waiver individual budget.

The UR process reviews the budget along with the support plan to ensure the level of need reflected in the budget is documented in the support plan and that services and amounts of service requested are necessary and consistent with the level of services other individuals who have a similar level of need receive. Historical costs and prior utilization data are also used to project costs and develop the budget. When an annual plan and budget are being renewed, historical costs and prior utilization data become the basis for calculating the new budget.

The individual is notified in writing of the approved budget and plan. The notice includes appeal rights should an individual disagree with the outcome. This process, which is in state regulation, is explained to individuals by the support coordinator and is available to the public from the State's DMH web-site.

Any time an individual's needs change, the support plan can be amended and a new budget can be prepared. If the new budget results in increased level of funding, the support plan and budget will be reviewed through the UR process before final approval is granted. If an increase in service are needed immediately an immediate increase can be approved out of the annual budget by the individual or their representative. The team must then meet to determine if an increase in the annual budget is necessary. The person centered planning process including the budgeting process is explained to individual by the support coordinator. Information on the person centered planning process and the UR process which is in state regulation, are available to the public from the State's DMH web-site.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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.

The method used to determine the individual budget is as follows. Needs of the individual are identified in the Support Plan. The individual along with the planning team determines how the needs can be best met through natural supports, or paid supports and a budget is drafted to meet the individual's needs.

The budget and support plan is reviewed by the Utilization Review (UR) Committee. UR considers the budget request in comparison with the level of funding that is approved for other individual with similar needs and either recommends the regional office Director approve the budget or approve the budget with changes.

The individual is notified in writing of the approved budget and support plan. The support plan has to be signed by the individual or guardian to be implemented. The notice includes appeal rights should a participant disagree with the support plan and budget.

The written notice includes information on the individual's right to a fair hearing and offers help with the appeal process. They may first appeal to the regional director. If they are dissatisfied, they have appeal rights through both the DMH and DSS. While individuals are encouraged to begin with the DMH's hearing system, they may skip this hearing process and go directly to the DSS, MHD (Single State Medicaid Agency) hearing system.

Individuals/guardians or designated representatives may request changes to budgets as needs change. For example, they may authorize more services be provided in one month and less in another month. Or, if needs increase, they may request additional services. When additional services are requested, the budget must be approved through the UR process. If an increase in service are needed immediately, an immediate increase can be approved out of the annual budget by the individual or their representative. The team must then meet to determine if an increase in the annual budget is necessary.

All regional offices administer the UR process according to state regulation. Individuals/guardians or designated representatives served by the Division of DD and providers are provided information on the UR process.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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:

Services are prior authorized on a yearly basis based on the needs and history of the individual. Individuals/guardians and designated representatives are informed of the amount of service that may be provided within that authorized period.

During the course of service implementation the individual, or if applicable, the designated representative, provides a monthly services summary to the support coordinator.

The support coordinator during service monitoring, on at least a quarterly basis and more frequently as needed, is responsible to

ensure that services are being delivered as they are authorized. If services are being underutilized, the support coordinator will seek to determine the reason for underutilization and will ensure the individual's health and safety are not at risk. The support coordinator is responsible for ensuring the individual has the necessary support to recruit, schedule and supervise employees and will assist the individual in accessing help as needed. A support broker assessment used to determine what supports are needed.

If an individual is at risk of exceeding the budget authorizations, the support coordinator will counsel the individual and document within the monitoring system. The Regional Office self-directed support coordinator will help create an improvement plan if needed. Also as part of the services approval process, the FMSP has a system that tracks real time service utilization for each individual. This is to ensure that only services authorized are billed.

The FMSP has safeguards and notification built in their system with alerts to the support coordinator and self-directed coordinator if an individual goes over authorizations. The FMSP posts real-time self-directed services allocations and usage on a secure, password-protected website for the benefit of individuals who are self-directing so they can keep track of budget utilization to date and amounts remaining in their allocation. This can be viewed by the individual, designated representative, support coordinator, and regional office designees. For individuals who self-direct services and utilize paper time sheets for their staff, the FMSP send out a monthly spending summary. If it is determined that the individual is at risk of exhausting budget allocation a support broker can be added to provide information and assistance to help individuals better manage the day to day activities of self-directing. If the issue cannot be resolved, the team may need to discuss termination of self-directed supports and transitioning to traditional agency provider supports.

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.

Medicaid rights of due process are extended to persons who participate in the DD MOCDD Waiver. Support Coordinators provide the division's rights brochure to individuals upon entry to the waiver and at least annually during the person centered planning process. In addition, information is posted on the division's web-site. Individuals have free choice of provider and have the choice of HCBS or institutional services.

When adverse action is necessary such as termination, reduction of services, suspension of services, etc. the support coordinator employed by the Division of DD Regional Office or TCM entity is responsible for notifying the participant in writing at least 10 days prior to any action being taken. Individuals have the right to appeal anytime adverse decisions are made or actions are taken. Support coordinators may provide assistance to individuals in pursuing a fair hearing if requested by the individual. Upon notification of the intent to appeal an adverse action, services are automatically continued until resolution of the appeal. Notification of appeal can be made either verbally or in writing to the DMH and/or DSS, MHD.

While not required to do so, individuals are encouraged to begin with the DMH's appeal process. The individual may, however, appeal to the MHD, before, during and after exhausting the DMH process. However, once the individual begins the appeal process with the DSS, all appeal rights with the DMH end since any decision by the single State Medicaid Agency would supersede a decision by DMH.

If the result of the agency's decision is upheld, the individual may be required to pay for the continued services. If the agency's decision is overturned, the individual is not responsible for the cost of services. Copies of written notices of adverse action and requests for a Fair Hearing are kept in the individuals record maintained by the regional office or TCM entity.

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.

(a) The Missouri DMH has an appeal process that can be utilized by individuals. Appeals are directed to the DMH Hearings Administrator in the Office of DMH General Counsel.

The Division of DD also has a UR Process defined in the Missouri Code of State Regulation (9 CSR 45-2.017) that applies to all regional offices. The Utilization Process is used to ensure that access to services are fair and consistent statewide, plans reflect individual's needs, levels of services are defined and documented within the outcomes of the plans, and plans meet all requirements. If through the UR Process the decision of the regional office director results in the denial, reduction, or termination of a specific service then the individual must be informed in writing at least 10 days in advance of the adverse action, must be given the reason for the action, and must be given information regarding his/her rights to appeal the decision of the regional office director.

(b) If an individual is notified by a regional office that they are ineligible for services or ineligible for continued services they may appeal the decision. (See below appeal process) If an individual is eligible for some services but not for a specific service the appeal steps are the same (as below) except that the individual must first appeal to the case management supervisor before appealing to the regional office director. The individual must appeal to the support coordinator supervisor in writing or orally within 30 days after being notified that they are ineligible for the specific service.

Appeal Process: The individual must appeal to the regional office director within 30 calendar days after receipt of written notice of their ineligibility. The individual will receive the regional office Director's decision on the appeal within 10 working days after the request for appeal is received. If the individual does not agree with the regional office director's decision the individual can, within 30 days after receiving that decision, notify the regional office intake or support coordination staff and request that an appeals referee hear the case. The individual will receive written notice that the Regional Office received their request for an appeal hearing. The appeals referee then notifies the individual in writing with the date, time, and location of the hearing. The notice is given to the individual at least 30 days before the hearing and no more than 60 days after the individual first requested the hearing.

An individual may receive documents that relate to their appeal without charge. The documents shall be furnished to the individual within five (5) working days after the individual requests the documents. The appeals referee bases his or her decision only on information presented at the hearing. The Regional Office director must convince the referee that the regional office's denial of services was correct.

During the hearing the individual, the individual's representative, or the regional office director may speak, present witnesses, submit additional information relating to the appeal, and question witnesses. The referee records the hearing and the tape is kept for one (1) year after the hearing and is available for review by the individual or their representative. Within 30 days after the hearing the individual receives written notice of the referee's decision.

If the individual disagrees with the referee's decision he or she may request that the decision be reversed or changed or appealed to the Director of the DMH. Within 30 days of the decision, the referee may reverse or change the initial appeal decision at the request of the individual, the individual's representative, or the regional office director.

If the individual appeals to the department director, the individual, the individual's representative, or the regional office director may present new evidence or comment on and object to the hearing decision within ten (10) working days of the individual's notice of appeal. The department director considers evidence contained on the tape recording of the appeals hearing and considers other evidence presented. Within 20 working days after receiving notice of an individual's intent to appeal the department notifies the individual and the regional office director of the department director's decision. That notice is the final decision of the DMH.

If the individual disagrees with the decision of the director of the DMH he or she may appeal to the Circuit Court, according to Chapter 536 of the Revised Statutes of Missouri (RSMo).

(c)Individuals can at any point in the DMH appeal process appeal to the DSS, MHD. However, once an appeal is filed with the DSS, all appeal rights with DMH cease since DSS is the single State Medicaid Agency and any decision through that agency would supercede a decision made by the DMH. Individuals and/or responsible parties are informed this dispute resolution mechanism is not a pre-requisite or substitute for a fair hearing.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

Missouri Department of Mental Health.

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).

The Office of Constituent Services (OCS) was created in 1997 to serve as an advocate for individuals who receive services from the DMH and their families. The office provides support to individuals and family members who have developmental disabilities, substance abuse problems, and mental illnesses. The main goals of the office are to ensure individuals' rights are not being violated; to review reports of abuse or neglect; and to provide useful information to individuals and family members about mental health issues.

(a) Individuals and family members may contact the office about suspected abuse, neglect, violation of rights, or concerns regarding mental health facilities or community providers by calling the toll-free number, completing and mailing a complaint form, sending an email to OCS, or writing to the DMH, OCS. Individuals are informed that the DMH complaint resolution mechanism is not a prerequisite or substitute for a fair hearing through the Medicaid Agency.

(b) & (c) When a complaint is received in the OCS the staff notifies the Division of DD's QE Leadership team as soon as the complaint is processed. All complaints received by the OCS are emailed/copied to the Division of DD QE Leadership team. The OCS includes the Event Report number on all correspondence for tracking purposes and includes the Event Report number in the subject box of the email.

Before the Division of DD is notified of a complaint the OCS checks the CIMOR System to verify the consumer or service is associated with the Division of DD before forwarding the complaint to the Division of DD.

(1) OCS e-mails information regarding the complaint within 1 working day to the designated DD facility.

(2) The DD Facility Director or designee determines if: (i) An Abuse/Neglect investigation is warranted, or (ii) An inquiry is warranted. (An inquiry is initiated when there is a complaint or suspicion of abuse, neglect, misuse of funds or property. (iii) All follow-up information regarding the complaint is forwarded within 10 working days to the local QE member with information that includes who was contacted, any follow-up that was, or is being done. This information is sent to the local QE member, who reviews the information for completeness. If the local QE member has questions, the response is returned to the DD Facility for clarification. Once the issues are adequately addressed, the complaint is forwarded to the Division of DD Consumer Safety Coordinator, who then reviews follow-up and resolves in the Event Management Tracking (EMT) System. (iv) If the person is not a DMH consumer or DMH does not have investigative authority and abuse or neglect is suspected, the DD Facility informs the OCS who then notifies the Family Support Division (FSD) if the individual is younger than 18 or the DHSS if the individual is 18 or older. The complaint is considered resolved upon referral to the appropriate investigative authority. (v) A complaint is not considered valid, if there is no apparent violation of a DMH standard, contract provision, rule or statute, or there is no valid concern that a practice or service is below customary business or medical practice. If the complaint is not valid it is considered closed upon receipt of the response.

(3) A complaint is resolved when: a) a complaint is resolved when all follow-up action is entered into the EMT system; b) the issues in the complaint are addressed by the facility; c) the reason the complaint is not a valid concern is explained.

The division's complaint resolution procedure is that within 10 business days, personnel designated by each DD facility will complete follow up to each complaint requiring a response to resolve with DMH OCS.

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).

System:
The state has a system for reporting and investigation of critical events or incidents. The system for identifying, reporting, and investigating critical events and incidents is outlined in the Code of State Regulations, the DMH Operating Regulations and Division of DD Directives.
Serious incidents:
In accordance with Department Operating Regulation 4.270 and Code of State Regulation 9 CSR 10-5.200 and 10-5.206, the state requires the reporting and investigation of critical events and incidents by all employees of state facilities and community contracted providers.
Critical events that are required to be reported are;
(A) Death of a consumer suspected to be other than natural causes;
(B) Serious injury to a consumer;
(C) Death or serious injury to a visitor at department state operated facilities;
(D) Death or serious injury to a department employee or volunteer while on duty;
(E) Incidents of abuse/neglect, including abuse/neglect involving death, serious injury and sexual abuse;
(F) Suicide attempt resulting in an injury requiring medical intervention (greater than minor first aid);
(G) Elopement with law enforcement contacted or involved;
(H) Criminal activity reported to law enforcement involving consumer as perpetrator or victim when the activity occurs at a facility. If not at a facility, then the criminal activity is serious (felony, etc.);
(I) Fire, theft, or natural disaster resulting in extensive property damage, loss or disruption of service and;
(J) Any significant incident the facility head, district administrator, provider administration or designee decides needs to be reported.
In addition to the DOR 4.270 list of critical events, DMH-DD Staff & Contracted Staff are also required to report the following events:
1. All events where there is a report, allegation or suspicion that an individual has been subjected to Misuse of Consumer Funds/Property, Neglect, Physical Abuse, Sexual Abuse or Verbal Abuse. (DOR 2.205)
2. All
a. Emergency room visits,
b. Non-scheduled hospitalizations,
c. Deaths of individuals served by DD,
d. Med Errors that reach an individual,
e. Incidents of Falls, The apparent (witnessed, not witnessed or reported) unintentional sudden loss from a normative position for the engaged activity to the ground, floor or object which has not been forcibly instigated by another person. The threshold is met when a participant is identified within the reported event with a role of "victim" and there are four or more reported fall events in one quarter. It is based on the number of falls that meet the division's criteria for a reportable event. The current criteria is defined as: The apparent (witnessed, not witnessed or reported) unintentional sudden loss from a normative position for the engaged activity to the ground, floor or object which has not been forcibly instigated by another person.
f. Uses of Emergency Procedures with an individual.
Emergency Procedures- any restraint/time out used by DMH staff or contracted staff to restrict an individuals' freedom of movement, physical activity, or normal access while in DMH services. If any of the following restraint types or time out occurs as defined they must be reported on an EMT form.
- Chemical Restraint- a medication used to control behavior or to restrict the individual's freedom of movement and is not a standard treatment for the individual's medical or psychiatric condition. A chemical restraint would put an individual to sleep or render them unable to function as a result of the medication. (A pre-med for a dental or medical procedure would not be reported as a chemical restraint.)
- Manual Restraint- any physical hold involving a restriction of an individual's voluntary movement. Physically assisting someone who is unsteady, blocking to prevent injury, etc. is not considered a manual restraint.
- Mechanical Restraints- any device, instrument or physical object used to confine or otherwise limit an individual's freedom of movement that he/she cannot easily remove. (The definition does not include the following: Medical protective equipment, Physical equipment or orthopedic appliances, surgical dressings or bandages, or supportive body bands or other restraints necessary for medical treatment, routine physical examinations, or medical tests; Devices used to support functional body position or proper balance, or to prevent a person from falling out of bed, falling out of a wheelchair; or Equipment used for safety during transportation, such as seatbelts or wheelchair tie-downs; Mechanical supports, supportive devices used in normative situations to achieve proper body position and balance; these are not restraints.)
- Time Out- removing the individual from one location and requiring them to go to any specified area, where that individual is unable to participate or observe other people. Time-out includes but is not limited to requiring the person to go to a separate room, for a specified period of time, the use of verbal directions, blocking attempts of the individual to leave, or physical barriers such as doors or ½ doors, etc. or until specified behaviors are performed by the individual. Locked Rooms (using a key lock or latch system not requiring staff directly holding the mechanism) are prohibited.

3. All events where there is Law Enforcement involvement when the DMH consumer is either the victim, alleged perpetrator, or law enforcement is support in the event.
4. All events that result in disruption of DMH service due to fire, theft or natural disaster; resulting in extensive property damage or loss.

5. All events where there is sexual conduct involving an individual and it is alleged, suspected or reported that one of the parties is not a consenting participant.
6. All events where there is any threat or action, verbal or nonverbal, which conveys a significant risk of immediate harm or injury and results in reasonable concern that such harm will actually be inflicted.
7. All events where the consumer ingests a nonfood item. Non-food item-an item that is not food, water, medication or other commonly ingestible items.
8. All events that result in a need for an individual to receive lifesaving intervention or medical/psychiatric emergency intervention.

In addition to the above list State Operated Programs (SOP)/Regional Office staff is required to report the following:

9. All events that involve Employee Misconduct as outlined in DOR 2.220
10. All events that involve a DMH staff with serious injuries as defined by DOR 4.270. Serious injury an injury that results in the hospital admission of the injured person.

The Physical Altercation Threshold is met when:

• A participant is identified within the reported event with a role of "alleged perpetrator" and there are seven or more reported physical altercation events in one quarter.
• A participant is identified within the reported event with a role of "victim" and injury was reported for one or more reported physical altercation events in one quarter.

The state defines abuse and neglect as:

Neglect- Failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any consumer when that failure presents either imminent danger to the health, safety or welfare of a consumer, or a substantial probability that death or physical injury would result.

Misuse of funds/property- The misappropriation or conversion for any purpose of a consumers funds or property by an employee or employees with or without the consent of the consumer or the purchase of property or services from a consumer in which the purchase price substantially varies from the market value.

Physical abuse- An employee purposefully beating, striking, wounding or injuring any consumer; in any manner whatsoever, an employee mistreating or maltreating a consumer in a brutal or inhumane manner; or an employee handling a consumer with any more force than is reasonable for an individual's proper control, treatment or management.

Verbal abuse- an employee making a threat of physical violence to a consumer, when such threats are made directly to a consumer or about a consumer in the presence of a consumer.

Sexual abuse- Any touching, directly or through clothing, of a consumer by an employee for sexual purpose or in a sexual manner. This includes, but is not limited to: 1. Kissing; 2. Touching of the genitals, buttocks, or breasts; 3. Causing a consumer to touch the employee for sexual purposes; 4. Promoting or observing for sexual purpose any activity or performance involving consumers including any play, motion picture, photography, dance, or other visual or written representation; 5. Failing to intervene or attempting to stop inappropriate sexual activity or performance between consumers; and/or 6. Encouraging inappropriate sexual activity or performance between consumers.

Who must report:

-Contracted providers of DD services immediately notify the Department with a written or verbal report of all required events of death, abuse, neglect or misuse of consumer funds/property or critical events. If a verbal report either by phone or in person is given, the contracted provider must send a completed event report form to the Department the next working day. All other events meeting the reporting criteria must be reported by the next business day.

-The Code of State Regulations (9CSR 10-5.206 and 9CSR 10-5.200) requires that any director, supervisor or employee of any residential facility, day program or specialized service, that is licensed, certified or funded by the DMH immediately file a written complaint if that person has reasonable cause to believe that a consumer has been subjected to abuse or neglect while under the care of a residential facility, day program or specialized service.

-For all Department employees, complaints of abuse, neglect, or misuse funds/property shall be reported and investigated as set out in Department Operating Regulation 2.205 and 2.210. These reports shall be entered into the EMT database within 24 hours or by the end of the next working day after the incident occurred, was discovered, or the notification was received.

Timeline:

All death, suspicions or complaints of abuse and neglect, and critical events shall be reported immediately. All other events meeting the reporting criteria must be reported by the next business day.

Method of reporting:

These events may be submitted in writing or verbally reported to DD regional office and Central Office employees. Any verbal report must be followed up with a written report form. There is a standardized Event Report Form.

Processing of reports:

-Event reports are forwarded to the head of the facility, day program or specialized service, and to the DD responsible state oversight organization. All reports of events are processed through the DD responsible state oversight organization. The DD responsible state oversight organization assures proper notification of Law Enforcement (when required), DHSS (when required) and Children Division (when required). If a report of suspected abuse and neglect is received, the DD responsible state oversight organization designated employee is also responsible for notifying the complainant and parent/guardian.

-The DD responsible state oversight organization requests an investigation through the DMH centralized Investigations Unit for all allegations of: Physical Abuse, Verbal Abuse, Neglect, Misuse of Consumer Funds/Property, and Sexual Abuse.

-In the case of a death the DMH notifies the Executive Director of Missouri Protection & Advocacy Services via e-mail of all consumer deaths that involve any or all of the following:

a. Death resulting from a consumer being restrained and/or secluded;
b. Death resulting from suicide;
c. Death deemed suspicious for abuse or neglect;
d. Any unexpected death; or
e. Death with unusual circumstances.

Information provided to Missouri Protection & Advocacy Services via e-mail to the Executive Director includes:

a. Consumer's name;
b. Consumer's guardian, if one is appointed;
c. Contact information for guardian;
d. Consumer's Social Security Number;
e. Consumer's date of birth;
f. Consumer's date of death

DD responsible state oversight organization directors, or designated staff, are required to report such deaths to their division directors (for community deaths) or the Director of Facility Operations (state operated) within 24 hours of notification of death.

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.

Training and information:

o Support coordinators annually provide training and education by reviewing a Client Rights brochure with consumers and guardians. The brochure specifies rights consumers receiving services through the Division of DD have under Missouri state law (Sec. 630.15, RSMo.) The brochure also informs consumers and their parents or guardians, they can contact the DMH OCS if they think they are being abused, neglected, or have had rights violated. Contact information includes e-mail address, a toll-free phone number and a toll phone number, fax number, and mailing address. Support Coordinators also obtain annually a signed Client's Rights Receipt to demonstrate rights information was provided to the consumer or legal guardian.

o The Missouri DMH has a web site http://dmh.mo.gov/ which provides consumers and families a link to the OCS where information about consumer rights, detecting and reporting abuse & neglect, the abuse/neglect definitions, and the Reporting and Investigation process which includes contact information. The DMH Client Rights brochure and other information regarding consumer rights and abuse/neglect is posted on this web site at http://dmh.mo.gov/constituentservices/. The site also has a consumer safety video at this site which discusses abuse and neglect and the reporting and investigation process, as well as the brochure Keeping Mental Health Services Safe which is a written version of the video.

o The brochure on Individual Rights of Persons Receiving Services from DD is located at http://dmh.mo.gov/docs/dd/indrights.pdf

Who is responsible:

o Assigned Division of DD or TCM entity support coordinators as discussed above.

o The Division of DD Consolidated Contract requires that each provider gives participants the name, address, and phone number to the DMH OCS. Each individual is informed that they have the right to contact this office with any complaints of abuse, neglect, or violation of rights.

Frequency of training:

o Annually with each consumer.

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.

Entities Receiving Reports:
Each DD responsible state oversight organization receives all written event report forms.
Report evaluation:
Reports are individually evaluated against set criteria for referral to the appropriate entity. The criteria for referral are as follows:
-All of abuse and neglect, and misuse of funds which meet the criteria for reasonable cause are submitted to the DMH Central Investigations Unit for investigation.
-If the provider reporting a critical event is responsible for the oversight/safety of the consumer, action must be taken to assure the welfare of the consumer. The DD responsible state oversight organization may intervene by placing monitoring processes and staff at the program site, moving individuals from a home and/or terminating contract when appropriate.
-If there is an allegation of abuse or neglect and the alleged victim is a resident or client of a facility licensed by the DHSS or receiving services from an entity under contract with DHSS then phone referral is made DHSS,
-If there is an allegation of abuse or neglect and the alleged victim is under 18 years of age a phone referral is made to Missouri DSS/Children's Division
-If there is alleged or suspected sexual abuse; or abuse and neglect that results in physical injury, or abuse/neglect or misuse of funds/property which may result in criminal charge this is reported to local law enforcement.
-Missouri Protection and Advocacy is notified by e-mail of all consumer deaths that involve any or all of the following:
-Death resulting from a consumer being restrained and /or secluded
-Death resulting from suicide
-Death deemed suspicious for abuse or neglect

-Any unexpected death; or
-Death with unusual circumstance.
Entity responsible for conducting investigations & timeframes:
Upon receipt of a report from the head of the DD responsible state oversight organization, or designee, the Central Investigations Unit assigns an investigator immediately. The assigned investigator initiates contact with the provider to arrange for securing evidence and such other activities as may be necessary.
A final report of the findings is sent to the DD responsible state oversight organization within 30 working days. Upon receipt of the final report the DD responsible state oversight organization director has 20 calendar days to make a determination. If the determination substantiates abuse or neglect the alleged perpetrator is notified by certified mail. The contracted provider is also notified in writing, required to take appropriate action, and must report an acceptable plan of correction to the DD responsible state oversight organization by a specified date. Further details including the appeals process are described in Department Operating Regulation 2.210 and 2.205.
Informing Participant:

The DD responsible state oversight organization notifies the consumer/guardian and follows-up by mail within 10 working days from receipt of an allegation if an investigation has been initiated. Immediately after an investigation is completed and after the effective date of any disciplinary action, the DD responsible state oversight organization provides written notification to the consumer/guardian of the findings of the investigation, a summary of the facts and circumstances and actions taken, except that the names of any employees or other consumers shall not be revealed.

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.

Entity for overseeing incident management system:
The Missouri DMH, Division of DD is responsible for the oversight of the state's event management system which currently includes one database: Event Management Tracking System (EMT). All critical incidents as defined in G 1-a, investigation findings and timelines are input into the EMT system.

Process of communication:
DD responsible state oversight organizations and support coordinators are notified of events including actions taken to protect the health, safety, and rights of the participants and to prevent reoccurrence.

Data collection:
-Designated DD QE Staff analyze aggregate reports of incidents from the EMT database at least quarterly, identifying trends and patterns. These identified trends are incorporated into provider Quality Management Plans, plans of action, and/or the participant's plan of care as indicated.
-Event data is reported in related performance measures to the Medicaid Agency quarterly.
-When there are consistent repetitive concerns or lack of progress on plans, the stakeholders of the provider are notified including the MHD (state Medicaid agency), DMH L&C, or the accrediting body (CARF or The Council on Quality and Leadership.)
- The Division of DD QE Leadership Team prepares statewide report which includes quality assurance and improvement recommendations to prevent reoccurrence of patterns, trends and systemic issues. Findings and recommendations are submitted to the Division Director of DD.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Mechanical restraints are not allowed in community settings. Physical restraint and chemical restraint may be permitted. Physical restraint is any manual hold of one person by another which restricts voluntary movement. Physical restraint does not include physically guiding a person during activities such as skill training. Chemical restraint is defined in section 630.005, RSMO, and these medications are only administered with the primary intent of restraining a patient who presents a likelihood of serious physical injury to himself or others, not prescribed to treat a person's medical condition. The administration of medication for chemical restraint must be ordered by a physician and the order must include specific instructions for when it may be used. All administration of medication for chemical restraint must be documented in the participant's record. Chemical restraint is administered only in an emergency situation where all other less restrictive interventions are tried first and found ineffective; there are clear indications of imminent harm to the individual or others; and is included in the person's safety crisis plan. If it is used, the consumer cannot be left alone after administration and the affects must be monitored and documented, including intended and unintended effects, side effects, breathing, consciousness, and allergic or other adverse reactions.

Physical restraint techniques are limited to those that have been approved by the Division and determined unlikely to cause undue physical discomfort, pain or injury to an individual and included in the individual's safety crisis plan. Requests for use of crisis management systems other than Mandt or Non-Violent Crisis Intervention/Crisis Prevention (NCI/CPI) must be made to the Chief Behavior Analyst of the division in writing, and quarterly analyses of use of the procedures and strategies to eliminate the need must be completed, documentation and submitted to the Chief Behavior Analyst.

In addition to those general concepts, staff is also required to have knowledge of the individual's personal plan which may include additional specific techniques to employ with the individual to avoid situations escalating to physical restraint use. During the use of physical restraint, staff must monitor for intended and unintended effects, including any adverse reactions, the individual's breathing, consciousness, position of limbs.

Physical restraint is used only in an emergency situation where all other less restrictive interventions are tried first and found ineffective; there are clear indications of imminent harm to the individual or others; and is included in the person's safety crisis plan.

There are prohibited restraint techniques that include physical restraint that interferes with breathing; any technique in which a pillow, blanket or other item is used to cover the face; prone restraint; restraints which involve staff lying or sitting on top of a person; and those that use hyperextension of joints.

The Division of DD supports the use of Positive Behavior Supports concepts. Staff is required to have an introduction to the concepts upon hire and, again, knowledge of the individual's personal plan which, if indicated for the individual, would include the positive supports to be implemented. Positive Behavior Supports are also designed to mitigate the use of restraint. The service contract for providers specifies that training of Mandt, CPI, or other approved system prior to utilization of the techniques is required. The training required for Mandt, CPI, and other systems is competency based.

The Division of DD has policies governing the use of restraint, and requires documentation of all uses of restraint. In addition, each contracted provider is required to have a policy for its organization around restraint. During Certification surveys, these policies are reviewed for content and compliance with state requirements. In addition, providers who are accredited by a nationally-recognized body must meet the standards outlined by that accrediting body, including any related to the use of restraint. Accredited providers are required to submit their current accreditation report and thus the Division is informed of conformance to those standards.

The division utilizes an EMT system to track reportable events in accordance with state regulation 9 CSR 10-5.206. An EMT Event Report form is completed by the persons involved in the physical and/or chemical restraint and these are sent to the DD State Responsible Oversight Organization for entry into the EMT system. Reporting is governed by Missouri administrative rules, known as Code of State Regulations (CSR). The DD State Responsible Oversight Organization reviews the event report and identifies, any unauthorized use of restraints. The support coordinator could also discover an unauthorized restraint was used through Service Monitoring (i.e. in conversation with the individual/staff, review of progress notes, etc.) A support coordinator could determine that the restraint is unauthorized if it is not implemented as outlined in the individual's safety/crisis plan or it is a restraint that is not approved by the Division.

Data is aggregated by region, by provider and by individual, analyzed and reported quarterly to further identify patterns and trends of use, both for consumer and for provider. Data is reported in related performance measures to the Medicaid Agency quarterly.

When a restraint is reported to the DD State Responsible Oversight Organization a designated staff reviews that event to determine if the restraint was a prohibited procedure or if more force than necessary was used in the restraint procedure. If the restraint is determined to be necessary to support the individual, it must be reviewed by the state responsible oversight organization due process committee.

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:

State and regional QE unit staff aggregate event (EMT) data to further identify patterns and trends. DD oversight state

responsible organization will conduct further analysis if trends or patterns of overuse, unauthorized use and/or ineffective use are noted.

Every two years a review by L&C staff of personnel records is completed as a component of the certification process to assure all staff have received the needed training regarding the individual plan, the basic concepts of Positive Behavior Support, and an approved physical crisis management system such as MANDT or CPI, if restraint is used for the individuals supported by the provider. The L&C staff also reviews policies and procedures for compliance with state requirements.

Providers who are placed on conditional certification status are reported to the MHD as it occurs. Any contract termination is reported to the MHD as it occurs.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive interventions may be utilized when a need for such a procedure is identified and described in an ISP or BSP that is a specialized part of the Individual's support plan written by a licensed behavioral provider. Relevant needs are situations in which the individual has frequently engaged in harmful behaviors and less restrictive procedures have not been successful, or as part of a legal arrangement such as when a person with sexual charges has been required to avoid certain public areas.

Through requirements of the waiver service definitions and provider contracts, staff are required to be trained on the ISP, BSP, and safety/crisis plan prior to implementing any individual restrictive interventions. Any staff utilizing restrictive interventions involving physical holds is required to be trained and competency-tested in MANDT or CPI or other Division approved physical crisis management system.

Any limitations or interventions imposed with regard to the restriction of participant movement, participant access to others, locations or activities, and restriction of participant rights must be reviewed by DD State Responsible Oversight Organization or the approved Due Process Review Committee and documented in the individual's plan.

The state does not allow the use of: Physical restraint techniques that interfere with breathing; or any strategy in which a pillow, blanket, or other item is used to cover the individual's face as part of a reactive strategy;
• Prone restraints (on stomach), restraints positioning the person on their back supine, or restraint against a wall or object;
• Restraints which involve staff lying/sitting on top of a person;
• Restraints that use the hyperextension of joints;
• Any technique which has not been approved by the Division, or for which the person implementing has not received Division-approved training;
Any reactive strategy that may exacerbate a known medical or physical condition, or endanger the individual's life, or is otherwise contraindicated for the individual by medical or professional evaluation;
• Containment without continuous monitoring and documentation of vital signs and status with respect to release criteria;
• Use of any reactive strategy on a "PRN" i.e., "as required" basis. Identification of safe procedures for use during a crisis in an individual's safety crisis plan shall not be considered approval for a restraint procedure on an as-needed basis;
• Aversive stimuli;
• Any procedure used as punishment, for staff convenience, or as a substitute for engagement, active treatment or behavior support services;

• Inclusion of a reactive strategy as part of a behavior support plan for the reduction or elimination of a behavior;
• Reactive strategy techniques administered by other persons who are being supported by the agency;
• Corporal punishment or use of aversive conditioning such as, but not limited to applying painful stimuli as a penalty for certain behavior, or as a behavior modification technique;
• Overcorrection by requiring the performance of repetitive behavior. Examples include, but are not limited to: Contingent exercise, writing sentences, over-cleaning an area, repeatedly walking down a hallway after running;
• Placing persons in totally enclosed cribs or barred enclosures other than crib; and
• Any treatment, procedure, technique or process prohibited by federal or state laws.

Less restrictive techniques, such as de-escalation, discussion, re-direction, for example, must be attempted before implementing any restrictions. Missouri State Statute outlines consumer rights and communication of any restrictions of those rights. If necessary for the individual's habilitation or therapeutic care, visitors, phone calls, clothing choices, carrying money on their person, television programming or reading materials and outdoor recreation may be restricted. The participant and guardian must be included and informed; and the criteria for removing any restrictions and timelines for reviewing must be documented in the individual's plan. For each episode in which restrictive interventions as outlined in the plan are implemented the following must be documented in the daily observation note: the circumstances and the situation, the less restrictive measures that were attempted, and the implementation of the restrictive intervention.

Any restrictions are required to be reviewed by DD State Responsible Oversight Organization or authorized due process review committee.

The Regional Behavior Support Review Committee will approve or deny restrictive procedures that are presented to the committee. The Behavior Support Review Committee will review the ISP and BSP to determine that least restrictive practices are being followed to ensure best behavior support practice. The review process includes teaching practices to develop alternative skills, fading of restrictive supports, and review of data toward progress to work toward elimination of the restriction. Additionally, the ISP and BSP must be reviewed by the Due Process committee in the region to evaluate that due process has been afforded the individual, the guardian or individual must consent to the use of the restrictive intervention, there must be an identified strategy for elimination of the restrictions and regular review of the progress towards this. This review would occur prior to utilizing the restrictive interventions and at least annually thereafter at the time of the annual plan development.

Any participant who has a grievance regarding their rights or a complaint may contact the DMH, OCS through the toll-free telephone line, through a dedicated e-mail address or by letter. Any of the Division's quality management functions may identify unauthorized use of restrictive interventions. The use of restrictive procedures that have not been identified in the ISP or BSP and have not been evaluated in the Due Process committee might be identified through the Support Coordination monitoring process, L&C survey process, the incident report review process in a regional office or through reporting by the individual, guardian, or other person.

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:

Any of the Division's quality management functions may identify unauthorized use, overuse, or inappropriate use of restrictive interventions.

The use of restrictive procedures that have not been identified in the ISP or BSP and have not been evaluated in the Due Process committee might be identified through the Support Coordination monitoring process, L&C survey process, the incident report review process in a regional office or through reporting by the individual, guardian, or other person.

The operating agency is responsible for the oversight of the state's DMH event management system CIMOR/EMT. All reported events are entered into the DMH Event management tracking system in CIMOR/EMT.

Support coordinators shall have the data from the event report for personal planning purposes. Information surrounding individual issues such as restrictive procedures are reviewed and discussed by the interdisciplinary team to ensure that safeguards for the individual are followed. The TCM TACS conduct the oversight to ensure the safeguards are occurring.

-Support coordinators conduct quarterly reviews of the support plan.

Division of DD responsible state oversight organization QE staff reviews reported data for patterns and trends quarterly. If a pattern or a trend is discovered, information is collected to ensure strategies are in place that will reduce the use of restrictive supports. The person’s plan is reviewed and, if necessary, revised.

Division of DD state-level QE staff aggregates data quarterly and reports through related performance measures to the MHD. They also provide summaries of the EMT data to the Division.

Data reported related to restricted procedures is aggregated specific to the participant. The data, upon aggregation, is analyzed and discussed by the interdisciplinary team to ensure that safeguards for the individual are followed and any necessary strategies are implemented to prevent re-occurrence.

Any participant who has a grievance regarding their rights or a complaint may contact the DMH, OCS through the toll-free

telephone line, through a dedicated e-mail address or by letter.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Seclusion time-out is allowed in community settings only after less restrictive techniques have been attempted and found ineffective. Seclusion time-out must be described in the behavior support plan approved by the division's Chief Behavioral Analyst. A functional assessment must be completed prior to inclusion in the plan; is time-limited; areas utilized must be safe and comfortable; must be continuously observed by staff; and cannot be locked.

Reporting is governed by Missouri administrative rules, known as CSR. The DD State Responsible Oversight Organization reviews the event report and identifies, any unauthorized use of seclusion. The support coordinator could also discover an unauthorized use of seclusion through Service Monitoring (i.e. in conversation with the individual/staff, review of progress notes, etc.

The use of alternative methods to avoid the use of seclusion.
The ISP and BSP are based on Person Centered Strategies and positive supports. When there is a request for use of seclusion time-out/(safe room), there is a review process undertaken by the Chief Behavior Analyst to determine if least restrictive strategies have been attempted. Staff are trained in various interaction skills and to use positive supports. For example, schedules could be rearranged and extra positive reinforcements for doing things not preferred to avoid escalation.

There are protocols that must be followed when seclusion is employed including the circumstances when its use is permitted. Utilization of a seclusion time out/(safe room) procedure requires that there be a functional assessment of the target behavior, a BSP, request to the Chief Behavior Analyst in writing specifying the rationale for the use of the procedure, and an approval of the designated time out area or room and time out shall only be included as a part of the BSP after a functional behavioral assessment provides indication that the behaviors targeted for intervention with the time out procedure will not be reinforced by the procedure, that there are high rates of positive reinforcement and engaging activities available for the individual making "time in" an enriched situation. These criteria are specified in the time out room/safe room review process.

Personnel administering seclusion time-out must have physical crisis management training and competency based implementation of time out. The LBA provides the training for implementers, monitors, and adjusts the intervention strategies.

When seclusion is administered, the incident is documented in the EMT. The BSP also includes data collection documenting the date, time in/out, and notes on monitoring during seclusion.

The use of seclusion time-out is considered a behavioral strategy and must be included in a BSP that is developed by a licensed behavioral provider (RSMo 337 (300 to 345) and 376 (1224).

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:

Seclusion time-out is allowed in community settings within BSPs approved by the division's Chief Behavioral Analyst. A CIMOR-EMT Event Report is completed by the persons involved in the event where seclusion was used. The event report is submitted to the DD Responsible State Oversight Organization for entry and review in the CIMOR- EMT System. If the report reaches criteria for an allegation of abuse or neglect an inquiry would be conducted to establish or rule out

reasonable cause. If reasonable cause is established a DMH investigation will be requested.

The Event Monitoring data is collected through the CIMOR system and is analyzed by the QE staff. Thresholds for review have been established and individuals who have met threshold in consecutive quarters receive more intensive review and follow up by regional QE staff. In addition the Regional Behavior Support Review Committees will be reviewing the strategies and supports for individuals who have approved time out strategies incorporated into their BSPs.

The DMH(Operating Agency) is responsible for methods to detect the unauthorized use of seclusion. Seclusion is considered a prohibited technique. Seclusion time-out is allowed in a BSP approved by the division's Chief Behavior Analyst. As outlined in the provider contract, if it occurs it is required to be reported as noted in Missouri administrative rules, known as CSR (9 CSR 10-5.206). The DD State Responsible Oversight Organization will identify the use of seclusion through any of the division's quality management functions.

As a key quality integrated function, support monitoring reports findings requiring remediation are entered into the APTS. The findings requiring remediation are then reviewed by the division. Support coordinator through the integrated quality function of support monitoring process communicates directly to the operating agency when findings requiring remediation are identified. These findings are also entered directly into APTS where the division reviews data quarterly for analysis.

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.

The entities that have ongoing responsibilities for monitoring participant medication regimens include the prescribing entities, contracted provider, and the Missouri Division of DD.
Scope of monitoring: The scope of medication monitoring is a holistic approach incorporating reviews by a medical professional of the medications prescribed, participant response and the delivery of their support service. The scope of monitoring incorporates two levels of review beyond the prescribing entity. The provider level includes oversight of all participants' medications and participant response by the provider RN. A second level of review by the Division of DD Regional Office Quality Enhancement RN (QE RN) includes consideration of medication categories including: anti-convulsants, anti-coagulants, and behavior modifying drugs when identifying the sample of cases to receive a full QE nursing review.
The first line of medication monitoring is conducted by the prescribing practitioner. In addition, the provider level includes oversight of all participants by the provider RN. A second level of review includes quarterly analysis of reportable event data in relation to medication errors as well as clinical QE RN reviews for all medication errors that meet the criteria of a serious or moderate medication area. Quarterly analysis of the data by the regional and state QE teams may result in systems improvement strategies at the individual, provider, regional and state level. The participant also receives on an annual basis an inventory completed by the support coordinator which identifies if the individual is currently prescribed certain medications including: anti-convulsants, anti-coagulants, and behavior modifying drugs this information as well as the individuals current prescribed medications are reviewed by regional office QE RN's if the individual meets the criteria for a QE RN nursing review.
Methods for conducting monitoring:
In the event the contractor is providing residential services, the contractor shall provide nursing oversight services for all residential consumers. Nursing oversight shall be provided by RNs licensed and in good standing in the state of Missouri. Nursing oversight activities shall include, but are not limited to:
a. regular monthly nursing functions specified by the Department for each consumer; The current nursing functions are identified in the community RN manual, which is available on the DMH website.
b. collaboration with designated Department staff in the implementation of statewide health and safety initiatives;
c. review and analysis of event reports for medication errors and injuries; and
d. completion of a Monthly Health Summary for each consumer.

Frequency of monitoring:

All DD Regional Offices have QE RNs who are responsible for monitoring participants' medication regimens as part of the

Health Identification and Planning System (HIPS). The health identification planning process for persons in residential services is completed annually, with significant health changes, and when entering placement for the first time.

The Division monitors on a quarterly basis for use of Psychotropic and Antipsychotic medications. The Division monitors for individuals identified through Medicaid claims billing where individuals are in receipt of 5 or more Psychotropic and/or 2 or more Antipsychotic Medications. Individuals identified as meeting this threshold are tracked in a SharePoint database.

Quarterly the State QE Unit review the tracking system to ensure that each individual on the list has follow-up information recorded. If no information for follow-up is noted the Regional QE staff are notified so that follow-up will be completed.

Each reported medication of error regardless medication type, if classified as moderate or severe receives a Clinical/QE Review conducted by the DD facility QE RN. Moderate medication errors are errors which result in treatment and/or interventions in addition to monitoring or observation. Serious classifications are errors which are life threatening and/or have permanent adverse consequences. The state will follow the process of additional inquiry into the event if it is suspected that the staff responsible for making the error did something or failed to do something which put the individual in imminent danger to the health, safety, or welfare of an individual or substantial probability that death or serious physical injury would result. If following the additional inquiry and the findings meet criteria for reasonable cause for suspicion of abuse or neglect, the event will be referred to the DMH investigation unit.

The Clinical/QE Review evaluates contributing factors to the medication error which may result in a Plan of Action to minimize the potential reoccurrence of future medication errors.

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.

The agency responsible for oversight is the MO DMH/Division of DD (operating agency). The operating agency monitors medication administration through the Division's Quality Functions for discovery, remediation, and quality improvement.

As part of the Division's EMT process, all medication errors that reach the "individual are required to be reported to the DD Responsible State Oversight organization. A clinical review is completed by a QE RN for all medication errors meeting the division definition of moderate or severe. All clinical review findings and actions are recorded in the EMT system. The clinical review is a form of risk mitigation, reducing risk factors associated with the event.
Medication errors where there is a suspicion of abuse, neglect, and/or misuse of funds meeting the criteria for reasonable cause are submitted to the DMH Central Investigations Unit for investigation.

During monitoring visits, support coordinators are expected to review documentation to assure all prescribed medications are administered, discovered errors are reported, and adequate supplies of medications are available.

The Division monitors on a quarterly basis for use of Psychotropic and Antipsychotic medications. The Division monitors for individuals identified through Medicaid claims billing where individuals are in receipt of 5 or more Psychotropic and/or 2 or more Antipsychotic Medications. Individuals identified as meeting this threshold are tracked in a SharePoint database.

Quarterly the State QE Unit reviews the tracking system to ensure that each individual on the list has follow-up information recorded. If no information for follow-up is noted the Regional QE staff are notified so that follow-up will be completed.

Each reported medication of error regardless medication type, if classified as moderate or severe receives a Clinical/QE Review conducted by the DD facility QE RN. Moderate medication errors are errors which result in treatment and/or interventions in addition to monitoring or observation. Serious classifications are errors which are life threatening and/or have permanent adverse consequences. The state will follow the process of additional inquiry into the event if it is suspected that the staff responsible for making the error did something or failed to do something which put the individual in imminent danger to the health, safety, or welfare of an individual or substantial probability that death or serious physical injury would result. If following the additional inquiry and the findings meet criteria for reasonable cause for suspicion of abuse or neglect, the event will be referred to the DMH investigation unit.

The Clinical/QE Review evaluates contributing factors to the medication error which may result in a Plan of Action to minimize the potential reoccurrence of future medication errors.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

In accordance with 9 CSR 45-3.070, staff who administer medication or supervise self-administration of medication to participants must be either a licensed physician; licensed nurse; or must be delegated the task of medication administration and supervised by a licensed medical professional. Persons who administer or supervise self-administration of medication to participants must be certified as a Medication Aide through the DMH or DHSS before being delegated and performing medication administration tasks.

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:

  In addition to appropriate follow up with medical professionals in response to medication errors, providers are responsible for documenting and reporting medication errors to their designated State Division of DD regional office in accordance with Event Reporting regulation 9 CSR 10-5.206. In addition, any action taken should be reported.

  Even reports are entered into the statewide EMT data base.

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

  In accordance with 9 CSR 10-5.206, Report of Events, providers are required to record any of the following medication error
  -Failure to administer;
  -Wrong Dose;
  -Wrong Medication;
  -Wrong Route;
  -Wrong Person;
  -Wrong Time;

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

  In accordance with 9 CSR 10-5.206 Report of Events, providers are required to report medication errors meeting the policy definitions of: In accordance with 9 CSR 10-5.206 Report of Events, providers are required to report any of the following medication error types that reach and individual;
  - Failure to administer;
  - Wrong Dose;
  - Wrong Medication;
  - Wrong Route;
  - Wrong Person;
  - Wrong Time
- ○ **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.

Oversight is conducted by the operating agency, Division of DD. In accordance with 9 CSR 10-5.206, medication errors are reported to the DD Responsible State Oversight organization using the standardized Event Report form. These reports are

entered into the statewide event database (EMT) and are tracked for analysis of trends and patterns at the provider, consumer, regional, and state level. Division of DD QE RNs also review medication error reports to identify patterns or trends for consumers and/or providers. The reports are also reviewed to ensure appropriate safeguard measures were taken.

If medication errors are noted in the records, the support coordinator may investigate further to ensure the errors were properly reported to the state in accordance with 9 CSR 10-5.206 and that all necessary corrective action was taken.
Quarterly the Division of DD's State QE Unit analyzes data to identify trends or patterns that may require additional actions for the provider, the region, or statewide.

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 of participant records that document the participant has been informed of how to report suspected abuse/neglect/misuse of funds divided by the number of participant records reviewed within the identified timeframe.

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

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

	☐ **Continuously and Ongoing**	☑ **Other** Specify: Representative sample.95 Confidence Interval that is stratified by region
	☐ **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 unexplained deaths for individuals with an open episode of care (Number of unexplained deaths of individuals with an open episode of care divided by Number of deaths of individuals with an open episode of care)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of EMT system events with a complaint or suspicion of abuse, neglect, misuse of funds or property, reported in the required timeframes.(Number of events with a complaint or suspicion of abuse, neglect, misuse of funds or property reported in the required timeframes divided by Number of events with a complaint or suspicion of abuse, neglect, misuse of funds or property)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of EMT system events where an inquiry was conducted within required timeframes. (Number of EMT system events within the identified quarter where an inquiry was conducted within required timeframes divided by Number of EMT system events within the identified quarter where an inquiry was conducted)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	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:

Performance Measure:
Number and percent of EMT system events where an investigation was initiated within required timeframes (Number of EMT system events where an investigation was initiated within required timeframes divided by Number of EMT system events where an investigation was initiated)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of moderate or severe med errors with a clinical QE review (Number of moderate and severe med errors from EMT with a clinical QE review divided by Number of moderate and severe med errors from EMT)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of choking events with a clinical QE review (Number of choking events entered in EMT with a clinical QE review divided by Number of choking events entered in EMT)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of individuals meeting the Division's established fall threshold for identified quarter with documented follow-up (Number of individuals with documented follow-up when meeting the Division's established fall threshold in the identified quarter divided by Number of individuals meeting the Division's established fall threshold in the identified quarter)

Data Source (Select one):
Trends, remediation actions proposed / taken
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of individuals meeting the Division's physical altercation threshold for the identified quarter with documented follow-up (Number of individuals with documented follow-up when meeting the physical altercation threshold in the identified quarter divided by Number of individuals meeting the physical altercation threshold in the identified quarter)

Data Source (Select one):
Trends, remediation actions proposed / taken
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 policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percentage of providers following state policy on prohibited procedures (Number of providers following state policy on prohibited procedures during the identified quarter divided by Number of providers during the identified quarter).

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

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of events entered into the EMT system where a Prohibited Procedure was used in accordance with policies and procedure. (Number of individuals where a Prohibited Procedure was used according to policies and procedures during the reporting period divided by the Number of events where a prohibited procedure was used entered into the EMT system during the reporting period).

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

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and

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

Performance Measure:
Number and percent of individuals whose health needs are being addressed according to support monitoring (Number of individuals without an entry into the APTS that requires follow-up relating to health in support monitoring divided by Number of individuals participating in the waiver)

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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.
All events entered into the EMT system require an electronic review be conducted by designated DD facility staff. Upon review of events entered into the EMT system individual problems may be discovered. When individual problems are discovered the designated DD facility staff conducting the event review will notify appropriate DD staff who will conduct further review to address the individual problem. The nature of the individual problem will determine what DD staff is responsible for addressing the issue. If further follow up is required, remediation of the individual problem is documented at the facility level and monitored through quarterly reviews at the state division level.

Remediation may be a coordinated effort by DD central office staff, DD facility staff, contracted provider, the person's planning team and other concerned parties which may include law enforcement or other state Departments. The state routinely monitors and evaluates events to ensure all individual problems have been reviewed.

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.

Overview:
The Division's quality management strategy includes multiple real-time methods of feedback and information gathering in addition to periodic inspection processes. Individuals (program participants) and community members are in active roles. The system utilizes quality improvement processes such as data analysis, tracking, and trending. Data bases are in place for gathering information and subsequent analysis and trending.
In addition to the statewide quality management functions completed by the Division of DD, there are functions completed by the DMH and other state agencies including the DSS/MHD, the Medicaid administrative agency. Each quality management function has its own guidelines, designated implementation staff, and process of identification, communication, and remediation. This allows for timely evaluation of information and development of an appropriate action plan for the individual

issue(s) identified. Systems improvement efforts are based upon the consolidation and analysis of data from all functions, as well as other information.
The following are the identified quality functions performed by the Division of DD.
-service monitoring: the process in which support coordinators review appropriate service provision, consumer well-being and, for participants in residential services, environment and safety, results of this process are entered into the APTS database;
-incident response: reporting, tracking and trending of identified incident/injury/medication error/restraint data, all information data based in the statewide EMT System;
-mortality review: the organized method of reporting and review of the circumstances of a consumer death while receiving funded services, requires local (regional office) review as well as a central office review, completed in a web-based database;
-HIPS and nurse review: the process in which support coordinators document potential health needs for consumers in residential services; when needs meet an identified threshold, an in-depth review by a QE RN is conducted and recommendations made for planning, risk mitigation and provider supports ;
-fiscal review for purchase of service system or Medicaid waiver programs or services: designated fiscal staff;
-service plan review: regional office staff review samples of plans for all waivers, samples are drawn by state-level QE staff with sample sizes using RAO-Soft, and findings requiring action of review are entered into APTS;
-the L&C process: Certification survey process for providers of residential, day service and employment services; conducted every other year, findings requiring action entered into APTS database.
-provider relations review: a review of provider business activities and contractual conformance done by regional provider relations staff at designated intervals and based upon trending of other quality function data reported to provider relations;
-quality of services review: regional office QE staff conduct one-one interviews and observations with participants. The Sample size is the same as required for the National Core Indicators (NCI) participation. Findings requiring action are entered into APTS.
-Data for trending, prioritizing, remediating and implementing system improvements is continually collected through the identified quality functions, entered into databases, and analyzed/reported at designated intervals. Reports are provided to Division management, regional level management and staff, providers, stakeholders, and the Medicaid agency at designated intervals, dependent upon the specified function and need. The state-wide QE Leadership Team provides the oversight, management and evaluation of the quality improvement processes/strategy for the Division of DD.
The Division reports quarterly to the Mental Health Commission on performance measures that the Commission identified; these performance measures overlap those used for waiver assurances and include abuse/neglect investigations, medication usage and medication errors, deaths, consumer injuries, use of restraints, and other indicators. The Mental Health Commission consists of community representatives in the field of behavioral health and intellectual and developmental disabilities appointed by the governor. This public forum is attended by providers and self-advocates and family members.
Reports are also shared with the Quality Advisory Council, a group of self-advocates and family members or guardians. The Quality Advisory Council represents a cross-section of advocacy groups, family members, consumers and public guardians. The Council reviews a wide variety of information from waiver performance, NCI, all quality integrated functions, current grants and Division initiatives.
In addition to the quality functions used by the state, DD participates in the NCI initiative. With 46 other states participating in this initiative, DD can compare results with a national average as well as the other participating states, using the information as benchmarks.
The process for trending is grounded in the CMS waiver quality assurances. Data is aggregated and reported state-wide, by individual region, and, at the regional level, by provider and consumer. The state QE Leadership Team tracks and evaluates remediation at the regional or state level for identified trends.
Process for Trending:

The state QE Leadership team analyzes and reports information to senior Division management and regional directors from service monitoring, service reviews, LOC, incident/injury, and abuse/neglect quarterly. These reports include summarizing performance in the identified areas, describing any patterns/trends, and discussing actions needed. These reports aggregate data state-wide and also aggregate by region. If trends are noted to occur within specific regions or with certain contracted providers, the Division of DD Statewide QE Team notifies Regional Office QE staff of the concerns to be addressed locally.
Regional staff review all integrated function databases for trends in service monitoring, incident/injury/abuse/neglect, remediation for service plan reviews, provider relations reviews, and QE reviews in their specific region to identify any significant patterns, trends, or concerns. These reports summarize regional trends for waiver and non-waiver services, specific provider issues and specific consumer issues. Each region develops reports on identified trends to be addressed locally with community providers and the Regional Offices.
Performance measures as outlined in each of the waiver quality assurances are analyzed and reported by state QE staff to the state Medicaid agency (MO HealthNet) quarterly. In addition to the written reports, the DD Federal Programs Unit, DD QE staff and the MHD meet quarterly to review the data reports/trends specific to each waiver and discuss other issues pertinent to the performance measures and the operation of the waivers.
When the Quality Improvement Strategy (QIS) spans more than one waiver information is stratified for each waiver. The sampling methodology is based upon a representative sample for each waiver and the QIS is reported in Appendix H for each waiver. QIS may span more than one waiver and is dependent upon the quarterly analysis of the data related to each specific performance measure. The majority of the performance measures for the five division operational HCBS waivers (MO.0178, MO.0404, MO.0841 and MO.40185) are consistent in what is being measured to meet a specific assurance and therefore QIS may impact all applicable waivers. There may be instances where a specific QIS is targeted to a particular waiver if performance is at or below 87%. No other long-term care services are addressed in the QIS.

Implementation of system improvements:
When patterns or trends are identified from the data and the reviews mentioned above, further analysis is conducted by the QE Leadership Team along with stakeholders who are involved in the identified trends. Work groups may then be developed to determine what systems improvement strategies could be developed to impact the areas identified. Sometimes this process results in policy/procedure changes, technical assistance with providers or private TCM entities, training with state staff, or it could be in the form of an awareness campaign to bring a more heightened attention to the identified situation.
Changes in rules, policy, and contracts are drafted and distributed to allow feedback from stakeholders. Once finalized, changes are distributed to Division DD's staff and contracted providers. Discussions are held at local provider meetings, as well as statewide coalitions of providers to assure that changes are understood and implementation dates are communicated. Any training required to assist with the implementation of these changes are initially planned and coordinated by the QE Leadership Team and then assumed by regional office staff. The implementation of system improvements is analyzed for effectiveness of remediation through periodic reviews, and through ongoing analysis of related data.

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.

Following implementation of revisions to rules, policy, practices, contracts, or training techniques, data is continually reviewed and analyzed as discussed above in system improvements, to assess effectiveness and appropriateness of the changes. The QE Leadership Team provides feedback and recommendations for system design changes to administration based on identification of trends.

Examples of system improvements:
Regular reviews of the abuse/neglect reporting data resulted in examination of the training components for this topic. Workgroups analyzed the abuse & neglect online training scores as well as comments from those who took the courses which then lead to changes which included examples that better described situations of abuse, neglect, and misuse of consumer funds. The training was revised and tests were re-designed. There has been a decline in abuse and neglect substantiations.

The process for development and revisions of Division Directives (policy and procedural requirements) has been altered to include public comments, identified trends and changes in programs. If a directive affects a broader base than just an internal work process, work groups are identified with representatives from the Division, Regions, providers and/or consumers of services for input. A draft of the Directive is posted on the Division's public web site for a comment period prior to finalizing and issuing the Directive. Anyone accessing the web site can register to have an automatic e-mail notification when changes to the site are made, documents posted and so forth.
A minimum set of incident data sets have been identified to assist in consistency of reporting and allows for comparisons state-wide and across regions.

A web-based survey has been designed that is filled out by all Regional QE staff upon completion of QE reviews related to Health and Safety to help evaluate the review process. This was successful in evaluating the survey process and the Provider Relations staff also implemented this for the Provider Relations Review. In addition, a web-based survey was established to allow providers to evaluate any contact/visit from regional staff.

Statewide training was implemented for support coordinators on how to use data to help identify areas of potential risk for consumers so that risk planning for the consumer would be addressed.

The APTS had two additional fields added: 1) Resolution Date- This allows us to identify issues that are unresolved for follow-

up. 2) Remediation and comments were added to each record so we can determine what measures are being taken to prevent the issue from occurring in the future.

We are currently in the process of redesigning the incident data collections system (EMT) department-wide. This was a result of data integrity reviews and data analysis. Changes to the system will ensure more consistency with data entry, a more user-friendly data entry, as well as providing additional information related to incident types. Input for changes to the system came from a variety of stakeholders including data entry staff, quality enhancement staff, providers, DD QA Advisory Council, habilitation center staff, and information technology staff.

The Division has tracked Medication Aide training and periodic updates for many years. The old data base was difficult to use, manage and was region-based, so did not "communicate" state-wide and thus was difficult to use for checking credentials. In fall 2010, a new web-based design was implemented that is much more user-friendly for data entry and also is available state-wide to check credentials. So, if a medication aide would move from the Joplin area, for instance, to St. Louis and began working for a provider, someone in St. Louis could check the data base to verify current Medication Aide certification.

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

There are several points at which the quality improvement strategy is evaluated. As data is reported at the identified intervals, data integrity and fidelity of the review processes are also evaluated. This allows an opportunity to impact design of the quality strategy, discovery processes, remediation effectiveness and methods, and prioritizing for systems improvement.

Each quarter at both the regional and state level, the results of the discovery processes are reported. This is also an opportunity to note changes, trends, and to identify if those trends indicate a need for updating the quality improvement strategy.

The results of the QIS is also combined with information from a variety of activities and stakeholder input that occurs within the Division and the DMH. For example, the Department participated in a personal planning grant which spanned both the Division of DD and Division of Comprehensive Services. The DD data related to the service planning assurances, gathered by the service plan review process, in addition to stakeholder meetings for the grant identified an opportunity to improve the planning process. Changes to the person-centered planning guidelines were achieved and also supported a risk assessment and mitigation component. This then circled back into revising some of the information asked in the discovery process for the service planning assurance - support plan review.

The state QE Leadership Team reviews trends every quarter and is responsible for identifying patterns or trends that would indicate need for changing of the strategy and/or activities supporting the implementation of the quality improvement strategy. Another example to illustrate this is the use of the EMT and classifying incidents accurately. Through the quarterly reporting process, the overuse of the category of "other" for incident type was identified. Since this system is an integral component of the quality improvement strategy, accurate data is crucial for identifying needed action. A two year project of intense review of how incidents were classified and technical assistance with regional QE staff and data entry personnel resulted in reducing the use of the category of "other" by 83%, and this category now is used for only about 2% of all reported incidents/injuries.

Another example of impacting the QIS is the regional office review of LOC, where they are now able to pull reports at the regional level to internally monitor and correct inaccuracies in data entry errors. The remediation is completed prior to the quarterly data extraction. This is a more proactive strategy rather than reactive.

On an annual basis, the QIS is evaluated and summarized in the annual report. When changes are needed, objectives are outlined and strategies to meet those objectives are identified and assigned. The information is presented to Division of DD management.

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).

a) Requirements concerning the independent audit of provider agencies:

Contract providers that provide services to individuals who participate in 1915(c) waivers administered by the Division of Developmental Disabilities (DD) are not considered sub-recipients as defined in 2 CFR 200.330 since they do not have responsibility for determining program and service eligibility and they do not make programmatic decisions.

Division of DD contract providers that expend $750,000 or more in federal grant funds received from the Department are required by the

Department of Mental Health (DMH) contract to have an annual audit conducted in accordance with 2 CFR 200.501.

Expenditures for this waiver are subject to the State of Missouri Single Audit conducted by the Missouri State Auditor's Office. Audits may be conducted by the Audit Services Unit of the DMH upon request. Audits may be requested by the Director of the DMH or the Director of the Division of DD based upon monitoring results, recommendations from regional offices, reports from provider staff, reports from the general public, etc.

b) As per the MOU between the DMH and the Department of Social Services(DSS) effective September 2011 there is a Missouri Medicaid Audit and Compliance Unit (MMAC) within DSS which directly manages and administers Medicaid program integrity, audit and compliance, and Medicaid provider contracts. The Division of DD is the division within DMH responsible for provision of services to individuals with developmental disabilities. Division of DD provides TCM and waiver services as part of their service delivery. MMAC and Division of DD work in conjunction with regard to assuring program integrity, audit and compliance for Medicaid services. More specifically MMAC conducts provider reviews to ensure provider qualifications and services rendered in accordance and compliance with the Medicaid Program, the support plan, waiver services program, and all applicable federal and state laws and regulations. MMAC will also conduct internal audits of Division of DD enrolled Medicaid waiver providers to ensure payments comply with HCBS waiver assurances.

c) Agency (or agencies) responsible for conducting the financial audit program:

1. The DSS MMAC reviews a sample of waiver provider billings and conducts compliance audits, annually, in which documentation of services provided is reviewed to ensure services are in compliance with policies/regulations, service billed to MO HealthNet (MHD) were provided, and services were documented as required; the MMIS includes edits to ensure appropriate payments.

MMAC utilizes both on-site and desk reviews. Providers are selected based on complaints, referrals, exception reports, direction from supervisor, or geographical area. Multiple factors contribute to whether an on-site or desk review is conducted. A desk review could escalate into an on-site review if there is difficulty getting the requested records from the provider or depending on the preliminary results of the desk review.

MMAC reviews many items to ensure services were rendered including but not limited to progress notes, employee time sheets, staffing patterns, and attendance records. MMAC also reviews the ISP and any exception approvals needed for any items exceeding the cost limits, which would explain the need for the service to be approved and why the limit was exceeded. MMAC also reviews budgets that are approved and based on waivers, we may question why cost limits were approved to be exceeded.

There are several ways of determining fraudulent billing activities. We compare staff timesheets with other places of employment for staff, investigative reports completed by DMH indicate problem areas such as staff not being present when 24 hour care is needed, no notes present or notes do not support time or service, verbatim notes from day to day, billing for services that could not have been performed such as after date of death, staff documenting is not the staff that is working, etc. Any type of fraudulent activity is sent to an investigative unit and can then possibly be referred to the Attorney General's office for additional follow up.

MMAC furnishes copies of the review findings to both Department of Mental Health and MO HealthNet. The DMH Office of Audit Services only performs financial audits on non-Medicaid services since the establishment of MMAC. The state auditor's annual Single State Audit includes a review of Medicaid waiver Documentation, but not specific to MOCDD.

Post Payment Review Sampling Methodology
1) Providers are selected for review based on complaints, referrals, exception reports, direction from supervisor, or geographical area.
2) Claims are selected for review based on abnormal billing patterns on the Truven (FADS) report, APTS reports that may identify issues, prior DMH-DD billing reviews.
3) MMAC does not do statistical samples for Waiver services.
4) MMAC reviews approximately 30% of enrolled Waiver providers annually
5) The time period for reviews can extend back 5 years. Depending on the type of review, 3 months or a year of claims could be reviewed during an audit.

2. State Auditor's Office conducts annual financial audits under the Single State Audit or based on information from stakeholders.

As part of the Medicaid provider enrollment process, all waivered service providers are required to have a DMH Purchase of Service contract. The DMH serves as the billing agent on behalf of all waiver service providers since the Department maintains the prior authorization system. This process pertains to all waiver services which are all prior authorized.

The Division of DD's automated network allows support coordinators to request services identified in the ISP. Before services are authorized, all new plans and plans requesting increased services must go through the regional office's Utilization Review (UR) process for approval. Approved services are input in the prior authorization system.

The Division of DD maintains a prior authorization system. The provider can access the authorization system online and bill for authorized services that have been delivered. Based on the Medicaid Agency published claims processing calendar, the claim data and any adjustments are approved by DMH central office and submitted to the Medicaid Agency's fiscal agent for processing.

Claims are submitted electronically to the MHD fiscal agent and are subjected to appropriate edits in the MMIS system to ensure that payment is made only on behalf of those clients who are Medicaid eligible, and to providers who are enrolled, on the date a service was delivered. The provider subsequently receives payment directly from the MHD as reimbursement for services rendered. A remittance advice indicating the disposition of billed services accompanies the provider's reimbursement.

The audit trail consists of electronic encounter documentation and claims data located in the DMH system, MHD, and with the provider of service. The Division of DD regional offices or contracted TCM entities maintain the ISP for individuals they support. The Division of DD also maintains billed claim data for all claims submitted to the MHD, Medicaid remittance advices, and a history of authorized and paid services by fiscal year. The information collected and maintained by the Medicaid agency's MMIS system includes: copies of all paid and denied claims; Medicaid remittance advices; and eligibility information on each individual served.

Providers are required to maintain financial records and service documentation on each person served in the waiver including the name of the participant, the participant's Medicaid identification number, the name of the individual provider who delivered the service, the date that the service was rendered, the units of service provided, the place of service, attendance and census data collection, progress notes and monthly summaries.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability Assurance:**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**
      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of paid claims for individuals enrolled in the waiver with the appropriate waiver modifier(Number and percent of paid claims for individuals enrolled in the waiver with the appropriate waiver modifier divided by number and percent of paid claims for individuals enrolled in the waiver)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Paid Claims; CIMOR screens that indicate dates individuals are actively enrolled in the waiver.

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 waiver service claims paid that did not exceed the maximum allowable rate. (Number of paid waiver service claims by procedure code that did not exceed the maximum reimbursement allowance/total number of paid waiver service claims)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report from MMIS of paid '85' DD waiver provider type claims.

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.

Performance Measure:
Number and percent of initial and amended waiver contracts implemented with the rate methodology described in the waiver (Number of initial and amended waiver contracts implemented with the rate methodology described in the waiver divided by Number of initial amended waiver contracts implemented)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Share Point, DD Reporting, Data Central, Report Manager.

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.
1. All waiver services are prior authorized. All approved waiver services for waiver-enrolled persons are input into the prior authorization system in CIMOR. DMH serves as the billing agent on behalf of all waiver service providers since DMH maintains the prior authorization system. The automated prior authorization system creates claims that are submitted

electronically to the MHD fiscal agent and subject to the appropriate edits in MMIS to include persons were Medicaid eligible and providers were actively enrolled with MO HealthNet on date of service.
2. Prior authorized services include the rate that is authorized. Only the amount authorized can be paid.
3. Payment is not made through the MMIS unless a valid waiver procedure code has been authorized and billed.

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.
1) For performance measure I.i.a.i.1, any claims billed to the MHD that are not covered waiver services will be adjusted so that reimbursement is returned to the MHD.
2) Performance measure I.i.a.i.2 involves tracking on a quarterly basis to ensure paid claims for an individual service recipient are applied to the waiver with which he or she is enrolled on each date of service. This is verified by comparing the date of service and eligible dates for the individual in receipt of the waiver. Any service claims paid for the individual outside of the eligibility dates will be returned to the MHD.

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).

Each Division of DD regional office has Provider Relations staff assigned to work with Division of DD waiver providers. The Division of DD is responsible for rate development. The rate methodology for each group of services is described below. A maximum allowable for each service is calculated and applied across all areas of the State. All maximum allowable rates are approved by the MHD. Service rates may be adjusted prospectively based on State budget appropriations.
Rates are developed for each waiver service using one of the following rate methodologies:
1. The fee schedule methodology is utilized for the following services: day habilitation — behavioral, day habilitation — medical, and

ABA. One statewide fee schedule rate is developed for each service and paid to all providers.
To develop the fee schedule rates, the following key cost components were considered for each service:
A. Staff wages
B. Employee benefits and other employee-related expenses
C. Productivity
D. Other service-related expenses
E. Administrative expenses
To model the cost components, various market data sources were reviewed including Bureau of Labor Statistics, Missouri-specific staff wages and Missouri-specific health exchange costs. The market assumptions for each cost component were factored together to develop an overall hourly rate, which was then converted to a "per unit" rate using the specific unit definition for each service (e.g., per 15 minute unit).
2. The negotiated market price methodology is utilized for the following services: environmental accessibility adaptations, specialized medical equipment and supplies, assistive technology, and transportation. For environmental accessibility adaptations, specialized medical equipment and supplies and assistive technology services, bids or cost estimates for a job/equipment/supply are obtained from two or more providers. The regional office reviews the quotes for reasonability and then authorizes a service price based on the provider with the lowest and best price. For community transition, and transportation services, a provider supplies cost information to the regional office for review and approval. For all these services, the authorized amount cannot exceed the maximum allowed rate set by the State for the service.
3. The Appropriated Fee Schedule is utilized for the following services: Day Habilitation, Community Integration, and Individualized Skill Development. Provider rates are based on actual historical state costs, which have been adjusted by appropriation passed by the Missouri General Assembly specifically to raise the lowest rates to a minimum fee schedule across all providers to stabilize provider capacity. Rates are adjusted as cost of living funds are appropriated.
4. The self-directed methodology is used for the following services: self-directed personal assistance, self-directed medical personal assistance and team collaboration personal assistance. Employers (families, individuals, guardians) are given a budget based on the necessary hours determined for the individual and the statewide average rate for agency personal assistance. The employer sets the actual wage of the direct care staff based on their budget authority and must stay within the budget. The per unit cost cannot exceed the maximum allowable rate set by the State.
5. Professional Services such as personal assistant, personal assistant – medical, person centered strategies consultation, support broker, community specialist, respite and crisis intervention reimbursement rates were established based on the expertise required of the professional/semi-professional and are comparable to rates that exist for similar services with comparable requirements.
The State re-examines rates at least once every five years, upon renewal of its waivers. Methods for reviewing rates include periodic market surveys, cost analysis and price comparison. At any time during the five-year period, re-evaluation of pricing and rate increases are considered as warranted based upon provider inquiries, service access and budgetary considerations. DDD monitors the number of providers delivering each waiver service, reviews participant complaints regarding ability to select/find a qualified provider, and considers participant feedback on service quality. Rate increases are determined by the State based on the outcomes of the periodic rate reviews performed by the State and available budget appropriations.

Individuals, providers, and other stakeholders have an opportunity to make public comments to the Division of DD, MO HealthNet, and elected officials on rates and methodology for rate setting during annual legislative hearings in preparation for the appropriation process. Many of the Medicaid maximum allowable rates have been adjusted over the years for cost of living adjustments (COLA) funding appropriated by the General Assembly. Individual rates may be adjusted for market or programmatic changes. For waiver submissions that impact rates, interested parties are notified by email blasts, online postings, postings in Regional Offices, and newspaper advertisements statewide informing of the 30 day public comment period and stakeholder forums. Additionally, providers and other stakeholders may provide comment to the Division of DD Director or DMH Director at any time regarding rates by writing a letter or during public meetings. Providers and other stakeholders may provide comment to the Division of DD Director or DMH Director at any time regarding rates by writing a letter or during public meetings.
During the person centered planning process when service providers are selected, the participant is informed of provider rates. Individuals in all areas of the state receive services based on their needs as indicated in the ISP (person-centered service plan), regardless of the cost per unit. Also, participants are given a copy of their approved budget which contains the rate for each service they are approved to receive.
All fee schedules are located at https://apps.dss.mo.gov/fmsFeeSchedules/maindisclaimer.shtml.

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:

The division contracts with TCM entities who may initiate the process for prior authorized services. Regional Office staff may also initiate the process for prior authorized services. The Division of DD automated customer information system allows staff of both the TCM entities and the regional offices to request prior authorization of services identified in the support plan. Before services are prior authorized, the support plan must go through the regional office or TCM entity's utilization review process if the plan is new or requests an increase in service. Final approval is performed by the Division regional offices. TCM providers are paid under State Plan for case management services and not the actual prior authorization of a service.

Since the prior authorization system resides in the DMH's information system, waiver providers are required to submit claims for services they provide through the operating agency's billing system and may not bill claims directly to MO HealthNet fiscal agent.

The automated prior authorization system creates claims that are submitted electronically to the MHD fiscal agent and subject to the

appropriate edits in MMIS to include persons were Medicaid eligible and providers were actively enrolled with MO HealthNet on date of service.

The ASC X12N 837 Health Care Claim format is used for billing waiver services. Claims submitted electronically are subjected to appropriate edits in the MMIS system to ensure that payment is made only on behalf of participants who are MO HealthNet eligible, and to providers who are enrolled, on the date a service was delivered. The provider receives a remittance advice indicating the disposition of billed services and any reimbursement due, directly from the MHD. The Division of DD also receives copies of remittance advices since the state share paid to providers is the Department's responsibility. The Division of DD is appropriated funds for the state share of waiver service programs it administers. As claims are adjudicated in the MMIS, Division of DD administratively transfers authority to the MHD to access the state share portion of the payment made for waiver services from this appropriation.

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:

(a) Waiver providers must submit bills through the DMH where the Division of DD's prior authorization system resides. Claims must successfully process through the prior authorization system before the Department sends the claims to the MHD fiscal agent for processing through the MMIS claims processing system. There are edits within the MMIS to verify eligibility for each date of service before the system approves payment to the provider. If an individual is not eligible for any date of service, the MMIS claims processing system does not allow payment to the provider for periods of ineligibility.

(b)&(c) Billing validation to determine if services are provided is done once a year as part of the MHD's review of a sample of waiver participants. The division reviews properly paid claims ongoing with quarterly and annually data analysis. Part of the process is to review the plan and ensure all service needs have been provided and that all services provided were included in the plan. Further, providers who received payment for services to participants selected for the review are contacted by MMAC and must provide

documentation that services were delivered. Anytime a claim is refunded or recouped due to inappropriate billings, the claim is adjusted in the system. The adjustment is reported on the CMS-64.

The MMAC conducts reviews of provider payments to ensure the provider has evidence/documentation that services were provided. Only authorized services are paid. Payment is made directly to the provider of service.

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:

Some county entities are reimbursed as waiver service providers, as well as Division of DD regional offices and habilitation centers. Out of Home Respite services may be provided as a direct service by a county entity, or an habilitation center. County Entities and Regional Offices may also provide the following services as a direct service: Day habilitation, in-home respite, personal assistant, support broker, community specialist, crisis intervention, Applied Behavior Analysis services, environmental accessibility adaptations, specialized medical equipment and supplies, assistive technology, or transportation. The county entity or regional office must have staff qualified to provide the service and must have been chosen by the participant to provide the service.

Both county entities and regional offices are more likely to provide waiver services under the Organized Health Care Delivery System (OHCDS) option, sub-contracting for waiver services from otherwise qualified providers that have chosen not to enroll as a MO HealthNet (Medicaid) provider.

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:*

- [x] **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:*

- [x] **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:*

- [x] **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.**
- [x] **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:

a) Entities that may be designated as an OHCDS are Division of DD regional offices and other MO HealthNet service providers that meet the requirements set forth in 42 CFR 447.10, and desire to serve as an OHCDS. There are no restrictions as to waiver services that may be provided under this option as long as all applicable provider standards are met for that service. State operated DD regional offices, county boards, and designated not-for-profit entities provide Medicaid State Plan TCM. They have systems capable of contracting and paying other providers directly. Other waiver providers of MHD services may also elect to become an OHCDS provider if they are approved by the local regional office and have systems capable of contracting with and paying waiver service providers directly and meet the assurances. The ability to contract directly with providers allows individuals and families to select and develop or train individuals they want to deliver services and care, thereby increasing the individual's self determination. The OHCDS option also enhances the availability and responsiveness of the service delivery system for individuals and their families.
(b) Any qualified provider of a waiver service may enroll directly with the MHD as a Division of DD waiver provider. Providers are not required to provide services through an OHCDS arrangement. The OHCDS option allows individuals and families the ability to select and develop or train individuals they want to deliver services and care, thereby increasing the individual's self determination. The OHCDS option also enhances the availability and responsiveness of the service delivery system for individuals and their families. Completing the enrollment process through the MO HealthNet program can take time. Contracting with an OHCDS qualified entity may be an expedient way to get services started. The option expands provider choice for individuals and families.

(c) Participants have free choice of qualified providers and are not required to access services through an OHCDS entity/arrangement. Providers are not required to contract with OHCDS entities, but may do so by choice. Qualified providers may enroll with MMAC to become a MO HealthNet Waiver provider.

(d) Provider agencies that have OHCDS designation have a specialized contract with the DMH and with MHD. The agreement specifies the following:
-Individual providers and agency providers are not required to contract with an OHCDS under the waiver.
-All persons or agencies which do contract with an OHCDS to provide waiver services must meet the same requirements and qualifications as apply to providers enrolled directly with the Medicaid agency.
-No OHCDS or contractor will be allowed to limit a participant's free choice of provider.
-Any state entity wishing to be designated an OHCDS must agree to bill the Medicaid program no more than its cost.
-All contracts executed by an OHCDS, and all subcontracts executed by its contractors, to provide waiver services, must meet the applicable requirements of 42 CFR 434.6 and 45 CFR Part 74, appendix G.

(e) MMAC is responsible for enrolling all waiver providers as Missouri Medicaid providers. A standard provider qualification for each waiver provider is that the provider has an active contract to provide waiver services for the Division of DD. This contract is required along with other MO HealthNet provider enrollment forms and any other proof of license or other credential in order for the provider to enroll as a Missouri Medicaid provider of waiver services.
In addition, support coordinators inform individuals of qualified providers and assist individuals in exercising choice. Regional offices use the OHCDS option to expand choice by contracting or until the provider enrollment process is completed.
(f) Regional Offices bill the same amount to the MHD as the Regional Office paid the contract provider. MMAC has the responsibility for reviewing paid claims. MMAC reviews paid claims by provider type or by specialty type if the provider type is too broad in scope. They select a sample within a set timeframe. Providers must maintain sufficient documentation to prove they provided services for which they were paid by the MHD. In addition, all services are prior authorized to qualified providers, by Regional Offices. Support Coordinators monitor services to determine if the services authorized in the plan are being received and if the services are meeting the individual's needs.

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:

a)The non-federal share is appropriated to DMH, Division of DD from General Revenue and Mental Health Local Tax Fund.

b) The State utilizes Intergovernmental Transfers (IGT). Funds from any local government (county boards) are deposited into the Mental Health Local Tax Fund with Division of DD, and expenditures for the State share for services in their county are made through Division of DD appropriations. MO HealthNet through the use of IGT directly accesses the Division of DD appropriations when making payments to providers. In addition, funds used for the state share for services delivered by private providers are also made through an IGT process from DMH general revenue 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:

a) Some Missouri counties have passed laws that give them authority to levy taxes for residents who have developmental disabilities. Legislation which allows an individual county to create a local DD authority and through a vote of the citizens of the county collect a special tax levied on property up to 40 cents per hundred dollars valuation on property. RSMo 205.968-205.973 is the statutory reference.

b) The source of their revenue is the special tax on property.

c) Funds from any local government (county boards) that are designated for the state share are deposited into the Mental Health Local Tax Fund with Division of DD, and expenditures for the State share for services in their county are made through Division of DD appropriations. MO HealthNet through the use of IGT directly accesses the Division of DD appropriations when making payments to providers.

☐ **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:

The only service that is provided in a residential setting is Out of Home Respite. FFP is not claimed for the cost of room and board.

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

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: ICF/IID

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	11014.40	24127.38	35141.78	258573.60	3900.10	262473.70	227331.92
2	11229.06	24658.18	35887.24	264779.37	3985.91	268765.28	232878.04
3	11440.11	25200.66	36640.77	271134.07	4073.60	275207.67	238566.90
4	11660.22	25755.08	37415.30	277641.29	4163.21	281804.50	244389.20
5	11877.31	26321.69	38199.00	284304.68	4254.81	288559.49	250360.49

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:
		ICF/IID
Year 1	366	366

Year 2	**366**	366
Year 3	**366**	366
Year 4	**366**	366
Year 5	**366**	366

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The Average Length of Stay was taken from the 372 Report based on the most recent FY15 372 report (306.6); 307 used in application.

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:

Factor D projections are based on actual service utilization data from the FY 15 CMS 372 report trended forward to WY 1 based on adjustments for program funding changes passed by the General Assembly. This information was applied to the total slots available in the waiver renewal. Although FY2015 unduplicated participants was 320, the state held the previously projected unduplicated participants (waiver slots) constant at 366 to allow for continued growth. FY2015 372 number of Users and Average Units per User were held constant for each service, since no additional waiver slots were requested. The total projected expenditure was then divided by the unduplicated number of slots available. The projected users for waiver services remain constant for years 2 -5 of the waiver. The unit costs for each waiver service was projected forward using an average trend of 1.9% for years 2 – 5 of the waiver application based on BLS trends.

Since, Home and Community Based waiver service costs (Factor D) are typically driven by changes in direct care wages (compensation), the BLS Employment Cost Index for Total Compensation was used. We utilized nationwide historical trends specific to the Healthcare and Social Assistance industry. The source link used to obtain the most current data is: https://www.bls.gov/news.release/eci.t05.htm. At the time of waiver submission, the most recent data available was for the 12 months ending September 2017, which reflected a 1.9% trend. This data point is located in Table 5 at the following link: https://www.bls.gov/news.release/archives/eci_10312017.htm.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is based on actual paid claims data from the FY15 CMS 372 report trended forward 2.2% annually based on BLS Medical CPI. Medical State Plan service projected costs (Factor D' and Factor G') were trended based on the BLS Consumer Price Index for all Urban Consumers (12 months ended November 2017). We used the nationwide historical trend across all categories since it wasn't significantly different than the historical trend on the medical services line. At the time of waiver submission, the most recent data available was for the 12 months ending November 2017. The source link used to obtain the BLS Medical CPI for State Plan services: https://www.bls.gov/opub/ted/2017/cpi-u-up-2-point-2-percent-over-12-months-ended-november-2017.htm (visited January 09, 2018). This cost was divided by the unduplicated number of persons receiving these services to compute an annual average cost.

There were no Medicare Part D figures in this data.

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 basis for determining Factor G for institutional costs was based on ICF/ID actual 2017 cost data for the four state habilitation centers. Factor G was trended annually by 2.4% based BLS trends. Direct care wages are one of the main drivers behind Intermediate Care Facility unit costs for Individuals with Developmental Disabilities (ICF/ID) (Factor G). Therefore, Factor G was trended based on the BLS Employment Cost Index for Total Compensation. We utilized nationwide historical growth rates specific to Nursing and Residential Care Facilities. The source link used to obtain the most current data is: https://www.bls.gov/news.release/eci.t05.htm. At the time of waiver submission, the most recent data available was for the 12 months ending September 2017, which reflected a 2.4% trend. This data point is located in Table 5 at the following link: https://www.bls.gov/news.release/archives/eci_10312017.htm.

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 basis for determining Factor G' for acute care costs for institutionalized participants was based on actual state plan claims data from 2017 for the four state habilitation centers. Factor G' was trended annually by 2.2% based on BLS Medical CPI. Medical State Plan service projected costs (Factor D' and Factor G') were trended based on the BLS Consumer Price Index for all Urban Consumers (12 months ended November 2017). We used the nationwide historical trend across all categories since it wasn't significantly different than the historical trend on the medical services line. At the time of waiver submission, the most recent data available was for the 12 months ending November 2017. The source link used to obtain the BLS Medical CPI for State Plan services: https://www.bls.gov/opub/ted/2017/cpi-u-up-2-point-2-percent-over-12-months-ended-november-2017.htm (visited January 09, 2018).

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
Day Habilitation
In Home Respite
Personal Assistant
Support Broker
Applied Behavior Analysis
Assistive Technology
Community Integration
Community Specialist
Crisis Intervention
Environmental Accessibility Adaptations-Home/Vehicle Modification
Individualized Skill Development
Out of Home Respite
Person Centered Strategies Consultation
Specialized Medical Equipment and Supplies (Adaptive Equipment)
Transportation

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
Day Habilitation Total:						**2287.42**
Day Hab, Group	15 Minutes	2	65.00	5.46	**709.80**	
Day Hab, Medical Exception	15 Minutes	1	101.00	8.10	**818.10**	
Day Hab, Behavior Exception	15 Minutes	1	101.00	7.52	**759.52**	
In Home Respite Total:						**72940.89**

In Home Respite - Day	Day	1	21.00	249.37	**5236.77**	
In Home Respite, Individual hourly	15 Minutes	19	670.79	4.98	**63470.15**	
In Home Respite, Group	15 Minutes	3	483.33	2.92	**4233.97**	
Personal Assistant Total:						**3184117.72**
Medical, Agency/Contractor	15 Minutes	101	2086.01	5.64	**1188274.74**	
Personal Assistant, Group	15 Minutes	1	2224.00	3.60	**8006.40**	
Personal Assistant, Individual/Agency	15 Minutes	38	1337.87	4.55	**231317.72**	
Personal Assistant, Self-Directed	15 Minutes	122	2739.64	3.55	**1186538.08**	
Medical, Self-Directed	15 Minutes	40	3077.65	4.63	**569980.78**	
Support Broker Total:						**2090.34**
Support Broker, Agency	15 Minutes	8	38.71	6.75	**2090.34**	
Applied Behavior Analysis Total:						**75258.63**
Adaptive Behavior Tx with Protocol Modification	30 Minutes	4	25.00	46.21	**4621.00**	
Adaptive Behavior Tx by Protocol by Technician	30 Minutes	9	132.86	17.82	**21308.09**	
Family Behavior Treatment Guidance Group	60 Minutes	6	18.00	56.15	**6064.20**	
Exposure Behavioral Follow-up Assessment	30 Minutes	14	1.00	46.21	**646.94**	
Exposure Adaptive Behavior Tx w/ Protocol Modification	60 Minutes	6	132.86	46.21	**36836.76**	
Behavior Identification Assessment	30 Minutes	14	1.00	184.82	**2587.48**	
Observational Behavioral Follow-up Assessment	30 Minutes	14	3.00	29.38	**1233.96**	
Behavior Treatment Social Skills Group	90 Minutes	11	18.00	9.90	**1960.20**	
Assistive Technology Total:						**4712.04**
Assistive Technology	1 job	6	1.00	785.34	**4712.04**	
Community Integration Total:						**53039.98**
Community Integration, Group	15 Minutes	0	0.00	5.46	**0.00**	
Community Integration, Individual	15 Minutes	4	1536.50	8.63	**53039.98**	
Community Specialist Total:						**6183.04**
Community Specialist, Self-Directed	15 Minutes	3	172.67	9.78	**5066.14**	
Community Specialist	15 Minutes	1	102.00	10.95	**1116.90**	
Crisis Intervention Total:						**632.40**
Crisis Intervention, Professional	1 Hour	1	4.00	71.98	**287.92**	
Crisis Intervention, Technician	1 Hour	1	8.00	43.06	**344.48**	
Environmental Accessibility Adaptations-Home/Vehicle Modification Total:						**225925.13**
Environmental Accessibility Adaptation-Home/Vehicle Modification	1 job	40	1.43	3949.74	**225925.13**	
Individualized Skill Development Total:						**19085.70**

Individualized Skill Development, Individual	15 Minutes	1	1689.00	5.94	**10032.66**	
Individualized Skill Development, Group	15 Minutes	1	1689.00	5.36	**9053.04**	
Out of Home Respite Total:						**7692.12**
Out of Home Respite, day	15 Minutes	3	23.00	111.48	**7692.12**	
Person Centered Strategies Consultation Total:						**55869.09**
Person Centered Strategies Consultation	15 Minutes	29	112.86	17.07	**55869.09**	
Specialized Medical Equipment and Supplies (Adaptive Equipment) Total:						**319874.62**
Specialized Medical Equipment and Supplies (Adaptive Equipment)	Each	126	6.25	406.19	**319874.62**	
Transportation Total:						**1562.33**
Transportation	Month	4	16.20	24.11	**1562.33**	
				GRAND TOTAL:		**4031271.45**
				Total Estimated Unduplicated Participants:		**366**
				Factor D (Divide total by number of participants):		**11014.40**
				Average Length of Stay on the Waiver:		307

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
Day Habilitation Total:						**2329.71**
Day Hab, Group	15 Minutes	2	65.00	5.56	**722.80**	
Day Hab, Medical Exception	15 Minutes	1	101.00	8.25	**833.25**	
Day Hab, Behavior Exception	15 Minutes	1	101.00	7.66	**773.66**	
In Home Respite Total:						**74401.93**
In Home Respite - Day	Day	1	21.00	254.11	**5336.31**	
In Home Respite, Individual hourly	15 Minutes	19	670.79	5.08	**64744.65**	
In Home Respite, Group	15 Minutes	3	483.33	2.98	**4320.97**	
Personal Assistant Total:						**3246500.56**
Medical, Agency/Contractor	15 Minutes	101	2086.01	5.75	**1211450.31**	
Personal Assistant, Group	15 Minutes	1	2224.00	3.67	**8162.08**	
Personal Assistant, Individual/Agency	15 Minutes	38	1337.87	4.64	**235893.24**	
Personal Assistant, Self-Directed	15 Minutes	122	2739.64	3.62	**1209934.61**	

Medical, Self-Directed	15 Minutes	40	3077.65	4.72	**581060.32**	
Support Broker Total:						**2127.50**
Support Broker, Agency	15 Minute	8	38.71	6.87	**2127.50**	
Applied Behavior Analysis Total:						**76682.65**
Adaptive Behavior Tx with Protocol Modification	30 Minutes	4	25.00	47.08	**4708.00**	
Adaptive Behavior Tx by Protocol by Technician	30 Minutes	9	132.86	18.16	**21714.64**	
Family Behavior Treatment Guidance Group	60 Minutes	6	18.00	57.21	**6178.68**	
Exposure Behavioral Follow-up Assessment	30 Minutes	14	1.00	47.08	**659.12**	
Exposure Adaptive Behavior Tx w/ Protocol Modification	60 Minutes	6	132.86	47.08	**37530.29**	
Behavior Identification Assessment	30 Minutes	14	1.00	188.33	**2636.62**	
Observational Behavioral Follow-up Assessment	30 Minutes	14	3.00	29.94	**1257.48**	
Behavior Treatment Social Skills Group	90 Minutes	11	18.00	10.09	**1997.82**	
Assistive Technology Total:						**4801.56**
Assistive Technology	1 job	6	1.00	800.26	**4801.56**	
Community Integration Total:						**54084.80**
Community Integration, Group	15 Minutes	0	0.00	5.56	**0.00**	
Community Integration, Individual	15 Minutes	4	1536.50	8.80	**54084.80**	
Community Specialist Total:						**6302.88**
Community Specialist, Self-Directed	15 Minutes	3	172.67	9.97	**5164.56**	
Community Specialist	15 Minutes	1	102.00	11.16	**1138.32**	
Crisis Intervention Total:						**644.44**
Crisis Intervention, Professional	1 hour	1	4.00	73.35	**293.40**	
Crisis Intervention, Technician	1 Hour	1	8.00	43.88	**351.04**	
Environmental Accessibility Adaptations-Home/Vehicle Modification Total:						**230217.42**
Environmental Accessibility Adaptation-Home/Vehicle Modification	1 job	40	1.43	4024.78	**230217.42**	
Individualized Skill Development Total:						**19440.39**
Individualized Skill Development, Individual	15 Minutes	1	1689.00	6.05	**10218.45**	
Individualized Skill Development, Group	15 Minutes	1	1689.00	5.46	**9221.94**	
Out of Home Respite Total:						**7838.40**
Out of Home Respite, day	Day	3	23.00	113.60	**7838.40**	
Person Centered Strategies Consultation Total:						**56916.43**
Person Centered Strategies Consultation	15 Minutes	29	112.86	17.39	**56916.43**	
Specialized Medical Equipment and Supplies (Adaptive Equipment) Total:						**325954.12**
Specialized Medical Equipment and Supplies (Adaptive Equipment)	Each	126	6.25	413.91	**325954.12**	

Transportation Total:						**1591.49**
Transportation	Month	4	16.20	24.56	**1591.49**	
			GRAND TOTAL:			**4109834.27**
			Total Estimated Unduplicated Participants:			**366**
			Factor D (Divide total by number of participants):			**11229.06**
			Average Length of Stay on the Waiver:			307

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
Day Habilitation Total:						**2374.31**
Day Hab, Group	15 Minutes	2	65.00	5.67	**737.10**	
Day Hab, Medical Exception	15 Minutes	1	101.00	8.41	**849.41**	
Day Hab, Behavior Exception	15 Minutes	1	101.00	7.80	**787.80**	
In Home Respite Total:						**75737.41**
In Home Respite - Day	Day	1	21.00	258.94	**5437.74**	
In Home Respite, Individual hourly	15 Minutes	19	670.79	5.17	**65891.70**	
In Home Respite, Group	15 Minutes	3	483.33	3.04	**4407.97**	
Personal Assistant Total:						**3308883.39**
Medical, Agency/Contractor	15 Minutes	101	2086.01	5.86	**1234625.88**	
Personal Assistant, Group	15 Minutes	1	2224.00	3.74	**8317.76**	
Personal Assistant, Individual/Agency	15 Minutes	38	1337.87	4.73	**240468.75**	
Personal Assistant, Self-Directed	15 Minutes	122	2739.64	3.69	**1233331.14**	
Medical, Self-Directed	15 Minutes	40	3077.65	4.81	**592139.86**	
Support Broker Total:						**2167.76**
Support Broker, Agency	15 Minutes	8	38.71	7.00	**2167.76**	
Applied Behavior Analysis Total:						**78150.18**
Adaptive Behavior Tx with Protocol Modification	30 Minutes	4	25.00	47.98	**4798.00**	
Adaptive Behavior Tx by Protocol by Technician	30 Minutes	9	132.86	18.51	**22133.15**	
Family Behavior Treatment Guidance Group	60 Minutes	6	18.00	58.30	**6296.40**	
Exposure Behavioral Follow-up Assessment	30 Minutes	14	1.00	47.98	**671.72**	

Exposure Adaptive Behavior Tx w/ Protocol Modification	60 Minutes	6	132.86	47.98	**38247.74**	
Behavior Identification Assessment	30 Minutes	14	1.00	191.91	**2686.74**	
Observational Behavioral Follow-up Assessment	30 Minutes	14	3.00	30.50	**1281.00**	
Behavior Treatment Social Skills Group	90 Minutes	11	18.00	10.28	**2035.44**	
Assistive Technology Total:						**4892.76**
Assistive Technology	1 job	6	1.00	815.46	**4892.76**	
Community Integration Total:						**55068.16**
Community Integration, Group	15 Minutes	0	0.00	5.67	**0.00**	
Community Integration, Individual	15 Minutes	4	1536.50	8.96	**55068.16**	
Community Specialist Total:						**6422.72**
Community Specialist, Self-Directed	15 Minutes	3	172.67	10.16	**5262.98**	
Community Specialist	15 Minutes	1	102.00	11.37	**1159.74**	
Crisis Intervention Total:						**1517.50**
Crisis Intervention, Professional	15 Minutes	1	102.00	11.37	**1159.74**	
Crisis Intervention, Technician	1 Hour	1	8.00	44.72	**357.76**	
Environmental Accessibility Adaptations-Home/Vehicle Modification Total:						**357.76**
Environmental Accessibility Adaptation-Home/Vehicle Modification	1 Hour	1	8.00	44.72	**357.76**	
Individualized Skill Development Total:						**243982.91**
Individualized Skill Development, Individual	1 job	40	1.43	4101.26	**234592.07**	
Individualized Skill Development, Group	15 Minutes	1	1689.00	5.56	**9390.84**	
Out of Home Respite Total:						**9390.84**
Out of Home Respite, day	15 Minutes	1	1689.00	5.56	**9390.84**	
Person Centered Strategies Consultation Total:						**7987.44**
Person Centered Strategies Consultation	Day	3	23.00	115.76	**7987.44**	
Specialized Medical Equipment and Supplies (Adaptive Equipment) Total:						**57996.50**
Specialized Medical Equipment and Supplies (Adaptive Equipment)	15 Minutes	29	112.86	17.72	**57996.50**	
Transportation Total:						**332151.75**
Transportation	Each	126	6.25	421.78	**332151.75**	
				GRAND TOTAL:		**4187081.39**
				Total Estimated Unduplicated Participants:		**366**
				Factor D (Divide total by number of participants):		**11440.11**
				Average Length of Stay on the Waiver:		307

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
Day Habilitation Total:						**2419.92**
Day Hab, Group	15 Minutes	2	65.00	5.78	**751.40**	
Day Hab, Medical Exception	15 Minutes	1	101.00	8.57	**865.57**	
Day Hab, Behavior Exception	15 Minutes	1	101.00	7.95	**802.95**	
In Home Respite Total:						**77187.73**
In Home Respite - Day	Day	1	21.00	263.86	**5541.06**	
In Home Respite, Individual hourly	15 Minutes	19	670.79	5.27	**67166.20**	
In Home Respite, Group	15 Minutes	3	483.33	3.09	**4480.47**	
Personal Assistant Total:						**3371266.22**
Medical, Agency/Contractor	15 Minutes	101	2086.01	5.97	**1257801.45**	
Personal Assistant, Group	15 Minutes	1	2224.00	3.81	**8473.44**	
Personal Assistant, Individual/Agency	15 Minutes	38	1337.87	4.82	**245044.27**	
Personal Assistant, Self-Directed	15 Minutes	122	2739.64	3.76	**1256727.66**	
Medical, Self-Directed	15 Minutes	40	3077.65	4.90	**603219.40**	
Support Broker Total:						**2211.12**
Support Broker, Agency	15 Minutes	8	38.71	7.14	**2211.12**	
Applied Behavior Analysis Total:						**79632.79**
Adaptive Behavior Tx with Protocol Modification	30 Minutes	4	25.00	48.89	**4889.00**	
Adaptive Behavior Tx by Protocol by Technician	30 Minutes	9	132.86	18.86	**22551.66**	
Family Behavior Treatment Guidance Group	60 Minutes	6	18.00	59.41	**6416.28**	
Exposure Behavioral Follow-up Assessment	30 Minutes	14	1.00	48.89	**684.46**	
Exposure Adaptive Behavior Tx w/ Protocol Modification	60 Minutes	6	132.86	48.89	**38973.15**	
Behavior Identification Assessment	30 Minutes	14	1.00	195.56	**2737.84**	
Observational Behavioral Follow-up Assessment	30 Minutes	14	3.00	31.08	**1305.36**	
Behavior Treatment Social Skills Group	90 Minutes	11	18.00	10.48	**2075.04**	
Assistive Technology Total:						**4985.76**
Assistive Technology	1 job	6	1.00	830.96	**4985.76**	
Community Integration Total:						**56112.98**
Community Integration, Group	15 Minutes	0	0.00	5.78	**0.00**	
Community Integration, Individual	15 Minutes	4	1536.50	9.13	**56112.98**	

Community Specialist Total:						**6543.58**
Community Specialist, Self-Directed	15 Minutes	3	172.67	10.35	**5361.40**	
Community Specialist	15 Minutes	1	102.00	11.59	**1182.18**	
Crisis Intervention Total:						**669.12**
Crisis Intervention, Professional	1 Hour	1	4.00	76.16	**304.64**	
Crisis Intervention, Technician	1 Hour	1	8.00	45.56	**364.48**	
Environmental Accessibility Adaptations-Home/Vehicle Modification Total:						**239049.10**
Environmental Accessibility Adaptation-Home/Vehicle Modification	1 job	40	1.43	4179.18	**239049.10**	
Individualized Skill Development Total:						**20200.44**
Individualized Skill Development, Individual	15 Minutes	1	1689.00	6.29	**10623.81**	
Individualized Skill Development, Group	15 Minutes	1	1689.00	5.67	**9576.63**	
Out of Home Respite Total:						**8139.24**
Out of Home Respite, day	Day	3	23.00	117.96	**8139.24**	
Person Centered Strategies Consultation Total:						**59109.30**
Person Centered Strategies Consultation	15 Minutes	29	112.86	18.06	**59109.30**	
Specialized Medical Equipment and Supplies (Adaptive Equipment) Total:						**338459.62**
Specialized Medical Equipment and Supplies (Adaptive Equipment)	Each	126	6.25	429.79	**338459.62**	
Transportation Total:						**1653.05**
Transportation	Month	4	16.20	25.51	**1653.05**	
				GRAND TOTAL:		**4267639.96**
				Total Estimated Unduplicated Participants:		**366**
				Factor D (Divide total by number of participants):		**11660.22**
				Average Length of Stay on the Waiver:		307

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
Day Habilitation Total:						**2465.53**
Day Hab, Group	15 Minutes	2	65.00	5.89	**765.70**	
Day Hab, Medical Exception	15 Minutes	1	101.00	8.73	**881.73**	
Day Hab, Behavior Exception	15 Minutes	1	101.00	8.10	**818.10**	

In Home Respite Total:						**78654.44**
In Home Respite - Day	Day	1	21.00	268.87	**5646.27**	
In Home Respite, Individual hourly	15 Minutes	19	670.79	5.37	**68440.70**	
In Home Respite, Group	15 Minutes	3	483.33	3.15	**4567.47**	
Personal Assistant Total:						**3433649.05**
Medical, Agency/Contractor	15 Minutes	101	2086.01	6.08	**1280977.02**	
Personal Assistant, Group	15 Minutes	1	2224.00	3.88	**8629.12**	
Personal Assistant, Individual/Agency	15 Minutes	38	1337.87	4.91	**249619.78**	
Personal Assistant, Self-Directed	15 Minutes	122	2739.64	3.83	**1280124.19**	
Medical, Self-Directed	15 Minutes	40	3077.65	4.99	**614298.94**	
Support Broker Total:						**2251.37**
Support Broker, Agency	15 Minutes	8	38.71	7.27	**2251.37**	
Applied Behavior Analysis Total:						**81148.99**
Adaptive Behavior Tx with Protocol Modification	30 Minutes	4	25.00	49.82	**4982.00**	
Adaptive Behavior Tx by Protocol by Technician	30 Minutes	9	132.86	19.22	**22982.12**	
Family Behavior Treatment Guidance Group	60 Minutes	6	18.00	60.54	**6538.32**	
Exposure Behavioral Follow-up Assessment	30 Minutes	14	1.00	49.82	**697.48**	
Exposure Adaptive Behavior Tx w/ Protocol Modification	60 Minutes	6	132.86	49.82	**39714.51**	
Behavior Identification Assessment	30 Minutes	14	1.00	199.27	**2789.78**	
Observational Behavioral Follow-up Assessment	30 Minutes	14	3.00	31.67	**1330.14**	
Behavior Treatment Social Skills Group	90 Minutes	11	18.00	10.68	**2114.64**	
Assistive Technology Total:						**5080.50**
Assistive Technology	1 job	6	1.00	846.75	**5080.50**	
Community Integration Total:						**57219.26**
Community Integration, Group	15 Minutes	0	0.00	5.89	**0.00**	
Community Integration, Individual	15 Minutes	4	1536.50	9.31	**57219.26**	
Community Specialist Total:						**6669.63**
Community Specialist, Self-Directed	15 Minutes	3	172.67	10.55	**5465.01**	
Community Specialist	15 Minutes	1	102.00	11.81	**1204.62**	
Crisis Intervention Total:						**681.88**
Crisis Intervention, Professional	1 Hour	1	4.00	77.61	**310.44**	
Crisis Intervention, Technician	1 Hour	1	8.00	46.43	**371.44**	
Environmental Accessibility Adaptations-Home/Vehicle Modification Total:						**243590.78**
Environmental Accessibility Adaptation-Home/Vehicle Modification	1 job	40	1.43	4258.58	**243590.78**	

Individualized Skill Development Total:						**20588.91**
Individualized Skill Development, Individual	15 Minutes	1	1689.00	6.41	**10826.49**	
Individualized Skill Development, Group	15 Minutes	1	1689.00	5.78	**9762.42**	
Out of Home Respite Total:						**8293.80**
Out of Home Respite, day	Day	3	23.00	120.20	**8293.80**	
Person Centered Strategies Consultation Total:						**60222.10**
Person Centered Strategies Consultation	15 Minutes	29	112.86	18.40	**60222.10**	
Specialized Medical Equipment and Supplies (Adaptive Equipment) Total:						**344893.50**
Specialized Medical Equipment and Supplies (Adaptive Equipment)	Each	126	6.25	437.96	**344893.50**	
Transportation Total:						**1684.15**
Transportation	Month	4	16.20	25.99	**1684.15**	

GRAND TOTAL:	**4347093.89**
Total Estimated Unduplicated Participants:	**366**
Factor D (Divide total by number of participants):	**11877.31**
Average Length of Stay on the Waiver:	307