

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:

No significant changes were made to this waiver. However, performance measures were updated by adding, modifying, or deleting performance measures. Other applicable areas in the waiver application were edited in order to ensure compliance with the Home and Community-Based Services Final Rule released by the Centers for Medicare and Medicaid Services (CMS).

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

1. Request Information (1 of 3)

- A. The **State of Missouri** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Medically Fragile Adult 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.40190

Draft ID: MO.016.04.00

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

Regular Waiver

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

07/01/16

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 in 42 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**☒ **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:

ICF/IID capable of caring for medically fragile individuals.

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 Eligibility for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Medically Fragile Adult Waiver (MFAW) will provide home and community-based services to participants with serious and complex medical needs who have reached the age of 21 and are no longer eligible for home care services available under Early Periodic Screening Diagnosis and Treatment (EPSDT), known as Healthy Children and Youth (HCY) in Missouri.

Goals are to: 1) Provide for cost-effective home and community-based services for participants as a cost effective alternative to Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/IID) placement and 2) Assure that necessary safeguards have been taken to protect the health and welfare of participants receiving services under the Medically Fragile Adult Waiver.

Objectives include: 1) Provide individual choice between ICF/IID institutional care and comprehensive community based care in a cost effective manner, 2) Maintain and improve a community based system of care that diverts participants from institutional care and residential care, 3) Ensure the adequacy of medical care and services provided through case management, 4) Monitor each participant's condition and continued appropriateness of participation through quarterly home visits by Department of Health and Senior Services (DHSS), Bureau of Special Health Care Needs (BSHCN) RN and 5) Monitor provider provision of service through care plan reviews and documentation that identifies the participants progress, the implementation of services and the appropriateness of the services provided.

The waiver is administered by the BSHCN through an interagency agreement with the Single State Medicaid Agency, Department of Social Services, MO HealthNet Division (DSS, MHD). BSHCN provides service coordination services for participants served by the Waiver.

Waiver services are accessed through referral to BSHCN RN for those participants who reach the age of 21, meet the criteria of the waiver and desire to remain in their homes. Referrals are also accepted from health care providers, families, other state agencies and other sources. The BSHCN RN completes assessments for waiver eligibility. A committee comprised of the BSHCN Bureau Chief and Program Manager makes the final determination of eligibility and services available.

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

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

- D. Participant-Centered Service Planning and Delivery.** **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- ☐ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

☒ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*
- F. Participant Rights.** **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** **Appendix H** contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- ☐ Not Applicable
- ☒ No
- ☐ Yes
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- ☒ No
- ☐ Yes

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

- ☒ **Geographic Limitation.** A waiver of statewide 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 statewide 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:

Input is obtained from family and participants during quarterly case management home visits and through participant surveys performed by BSHCN. BSHCN solicited additional public comment through notification by direct email and in a department published newsletter, which is distributed statewide.

MHD publishes notice of waiver amendments/renewals on the MHD website with a link to review the entire waiver application. MHD also publishes notice of waiver amendments/renewals in the 5 newspapers in Missouri with the greatest population. The notices published on the website and in the newspapers notify the public of two (2) upcoming public forums. The public forums will be held in a public place. Public may attend the forums in person or via conference call/telephone line. Copies of the waiver renewal are available during the public forums. Copies of the waiver amendments/renewals will also be available at all regional offices in Missouri. Once the notice is published in the newspapers, the public have 30 days to either mail or email comments to MHD. MHD and BSHCN will consider all comments and make a determination on whether or not changes are required in the waiver renewal. If changes are required, they will be made to the waiver application and the public input process will begin again. If no changes are required, MHD will summarize the comments and report to CMS.

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

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

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

7. Contact Person(s)

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

Last Name:

Glenda

First Name:

Kremer

Title:

Director, Program Operations

Agency:

Missouri Department of Social Services, MO HealthNet Division

Address:

P.O. Box 6500

Address 2:

615 Howerton Court

City:

Jefferson City

State:

Missouri

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Missouri**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will

continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:**First Name:****Title:****Agency:****Address:****Address 2:****City:****State:****Missouri****Zip:****Phone:**

Ext:

☐ TTY**Fax:****E-mail:****Attachments**

Attachment #1: Transition Plan

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

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

- ☐ Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- ☐ Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

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

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

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

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

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

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Missouri Home and Community Based Services (HCBS) 1915(c) Waiver Settings Statewide Transition Plan

Missouri administers ten Home and Community Based Waivers through Department of Social Services, MO HealthNet Division(MHD), which is the single State Medicaid agency. The day-to-day operation of the waivers is through formal cooperative agreements with the Missouri Department of Mental Health (DMH) and the Missouri Department of Health and Senior Services (DHSS). The Department of Health and Senior Services and the Department of Mental Health are the operational entities for the waivers.

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

The transition plan incorporates all ten DHSS and DMH waivers and has been jointly developed by the Department of Social Services/MO HealthNet Division, the Department of Mental Health and the Department of Health and Senior Services. The transition plan as outlined below will have sections that apply exclusively to waivers operated by DHSS, waivers operated by DMH, or both state agencies, herein referred to as State.

The MO Department of Health and Senior Services operates the following 1915 (c) Waivers (DHSS Waivers):

- Adult Day Care Waiver (MO.1021)
- Aged and Disabled Waiver (MO.0026)
 - o All services, except Adult Day Care Services, in the Aged and Disabled Waiver are received and administered in the participant's home. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants

are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

- AIDS Waiver (MO.0197)

- o Only one setting, Doorways, is under heightened scrutiny. All other participants receive services in their homes. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

- Independent Living Waiver (MO.0346)

- o All services in the Independent Living Waiver are received and administered in the participant's home. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

- Medically Fragile Adult Waiver (MO.40190)

- o All services in the Medically Fragile Adult Waiver are received and administered in the participant's home. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

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

- Autism Waiver (MO.0698)
- Comprehensive Waiver (MO.0178)
- Missouri Children with Developmental Disabilities Waiver (MO.4185)
- Partnership for Hope Waiver (MO.0841)
- Support Waiver (MO.0404)

The remainder of Missouri's STP has not been outlined below as there is no additional information pertaining to the MFAW. MHD has found that MFAW settings are compliant with the HCBS Final Rule Settings criteria. Below are reasons why MHD has come to that conclusion.

Participants are making the choice to stay in their homes and not be placed in a residential setting when enrolling in the Medically Fragile Adult Waiver. All services in the MFAW are administered and received in the participants' homes. These services are administered without restricting the participant's access to the community. Participants enrolled in the MFAW live in the greater community to the same degree as individuals not receiving Medicaid HCBS. These homes are owned/rented by the participant/caretaker.

Some MFAW participants choose to seek employment/volunteering. Some participants have jobs but some choose not to seek employment due to the complexity of their medical/physical needs. The MFAW provides supports to all MFAW participants to meet their individual needs in the choices they make.

All participants have the choice/opportunity to engage in community life. Through the MFAW, private duty nursing and waiver attendant care services staff are able to provide supports both within the home and outside the participant's home in order to engage in community life.

The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual autonomy and independence in making life choices including but not limited to, daily activities, physical environment and with whom to interact. The participant's home allows for privacy, freedom to furnish/decorate their rooms, control their activities, and have access to food at all times.

MFAW participants are provided a choice of receiving the MFAW or alternate care. The MFAW Client Choice Statement

is signed by the participant annually. MFAW participants are provided with a list of agencies which offer services authorized through the MFAW. The MFAW participants are offered their choice of provider agencies initially and upon request.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

- ☐ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Department of Health and Senior Services, Bureau of Special Health Care Needs (DHSS, BSHCN)

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 Department of Health and Senior Services, Bureau of Special Health Care Needs (BSHCN), 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 BSHCN meet quarterly to discuss administrative/operational components of the Medically Fragile Adult Waiver. This time is also used to discuss the quality assurances as outlined in the waiver. Through a Memorandum of Understanding that exists between the two (2) agencies, communication remains open and additional discussions occur on an as needed basis.

MHD conducts an analysis of quarterly and annual reports submitted by the BSHCN 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, 2) Plan of Care, 3) Qualified Providers, 4) Health and Welfare, 5) Administrative Authority, and 6) Financial Accountability. A formal report is provided to the BSHCN outlining the results of the analysis and listing any areas for improvement. The BSHCN 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 the BSHCN to monitor areas of deficiencies, to set goals and establish timeframes for compliance.

The MHD monitors through the quarterly meetings, review of statistical reports and the annual record review that the BSHCN is providing oversight for disseminating information concerning the waiver to potential enrollees, assisting individuals in waiver enrollment, ensuring waiver enrollment is managed against approved limits, ensuring waiver expenditures are managed against approved levels, conducting level of care evaluation activities, appropriately reviewing participant service plans, accurately prior authorizing services, and ensuring utilization of services is appropriately managed. Statewide rate methodology is jointly established by the MHD and the BSHCN. All rules, policies, procedures and information development governing the waiver program is discussed by the BSHCN with MHD prior to implementation.

BSHCN and MHD staff meet quarterly in order to demonstrate adequate mechanisms are in place for identifying and resolving problems to ensure the health and welfare of waiver participants and that waiver requirements are being monitored.

The responsible administrators of this waiver meet and consult on a regular basis by phone or email as needed and through quarterly face-to-face meetings.

Appendix A: Waiver Administration and Operation

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

- ☐ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

Appendix A: Waiver Administration and Operation

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

☒ **Not applicable**

☐ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid

Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of waiver service units authorized that were delivered based on billable units of service. Numerator = Total number of waiver service units authorized

by procedure code. Denominator = Total number of waiver services billed by service procedure code.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:**Number and percent of manuals and directives reviewed by MHD prior to issuance.****Numerator = Number of manual and directives reviewed by MHD prior to issuance.****Denominator = Total number of manual and directives issued.****Data Source** (Select one):**Other**

If 'Other' is selected, specify:

MHD tracking

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of total dollars for services paid divided by approved waiver expenditures. Numerator = Total dollars for services paid. Denominator = Total approved waiver expenditures.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

MMIS

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

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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- 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.

While the current process meets the federal quality reporting requirements, MHD and BSHCN will continue to research methods to enhance reporting capabilities. Once improvements are identified, the state will include this information on the CMS-372 report.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
- Issues which require individual remediation may come to MHD's attention through review of BSHCN reports, as well as through day-to-day activities of the MO HealthNet Division, e.g., review/approval of provider agreements, utilization review and quality review processes, complaints from MO HealthNet participants related to waiver participation/operation by phone or letter, etc. MHD addresses individual problems related to delegated functions as they are discovered by contacting DHSS and advising them of the problem. A follow-up memo or email is sent from MHD to BSHCN identifying the problem and if appropriate a corrective action resolution. While some issues may need to be addressed immediately, BSHCN is required to provide a written response to MHD that specifically addressed the problem identified by MHD. Written documentation is maintained by both MHD and BSHCN and, as needed, discussions will be included at the quarterly meeting. Any trends or patterns will be discussed and resolved as appropriate. Individual problems that are part of the report process will be included in the appropriate reports. The MO HealthNet Waiver Review Log will include an analysis of data received from DHSS and data generated by MHD for the purpose of identifying the number and percentage of issues addressed.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually
Specify: <div></div>	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other
	Specify: <div></div>

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
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<div></div>	<div></div>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<div></div>	<div></div>	
	<input type="checkbox"/>	Disabled (Other)	<div></div>	<div></div>	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<div></div>	<div></div>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<div></div>	<div></div>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<div></div>	<div></div>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<div></div>	<div></div>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism	<div></div>	<div></div>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	21	<div></div>	<input checked="" type="checkbox"/>
		Intellectual Disability			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

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

Individuals who had a documented need for Private Duty Nursing Services prior to age 21 as provided under the EPSDT program or who received services under the Children's Waiver that was discontinued June 30, 1992.

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

- ☒ **Not applicable. There is no maximum age limit**
- ☐ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

- ☒ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ☐ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

- ☐ **A level higher than 100% of the institutional average.**

Specify the percentage:

- ☐ **Other**

Specify:

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

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

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

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

- ☐ **The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

- ☐ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	210
Year 2	235
Year 3	260
Year 4	285
Year 5	310

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

- e. Allocation of Waiver Capacity.**

Select one:

- ☒ **Waiver capacity is allocated/managed on a statewide basis.**
- ☐ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

The state provides for the entrance of all waiver eligible persons.

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:

Section 1902(1), 1905(n) and 1925 of the Social Security Act

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- ☐ A special income level equal to:

Select one:

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

Specify percentage:

- ☐ A dollar amount which is lower than 300%.

Specify dollar amount:

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

Select one:

- ☐ 100% of FPL
☐ % of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community

spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- ☐ **Other**
Specify:

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

Must be a registered nurse, licensed in the State of Missouri.

- 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.

As specified in 19 CSR 30-18.030 the following criteria are used to evaluate and reevaluate whether an individual meets ICF/IID level of care.

1. MONITORING:

- 0 points Frequent visits by friends or neighbors and/or RN visits for state plan personal care.
- 3 points Client is seen regularly by physician and/or seen by home health for stable condition.
- 6 points Client is seen regularly by physician and/or home health for unstable condition.
- 9 points Client requires intensive monitoring for unstable condition.

2. MEDICATION:

- 0 points Client takes no prescription meds and/or only occasional prn meds.
- 3 points Client takes prescription meds and/or prn meds on a regular basis.
- 6 points Client needs supervision taking meds and/or needs meds set up on a regular basis.
- 9 points Client has complex drug regimen requiring high number of meds, varying times, special instructions and/or total assistance to take meds.

3. TREATMENT:

- 0 points No treatments ordered by physician.
- 3 points Client has physician ordered treatments such as simple dressing, whirlpool baths, external catheter or regulated ostomy.
- 6 points Client has physician ordered treatments that require daily attention of licensed personnel.
- 9 points Client needs maximum type treatments requiring direct supervision by professional such as intratracheal suctioning, continuous oxygen, etc.

4. RESTORATIVE SERVICES:

- 0 points No physician services ordered for range of motion, bowel and bladder programs, self care, etc.
- 3 points Physician ordered teaching activities to maintain current level of functioning.
- 6 points Physician ordered services designed to help client achieve optimal level of care.
- 9 points Physician ordered services with goal to restore client to higher level of functioning (intense-requiring professional supervision)

5. REHABILITATION:

- 0 points No rehabilitation services required.
- 3 points Rehabilitation services ordered one time per week.
- 6 points Rehabilitation services ordered 2-3 times per week.
- 9 points Rehabilitation services ordered four or more times per week.

6. PERSONAL CARE

- 0 points Client is independent in activities of daily living.
- 3 points Client requires minimal or occasional assistance with ADL's.
- 6 points Client requires daily assistance with ADL's and/or is incontinent of bladder and bowel 50% of the time.
- 9 points Client requires total assistance with ADL's.

7. BEHAVIOR/MENTAL CONDITION

- 0 points Client is oriented and requires little or no assistance from others.
- 3 points Client has occasional memory lapses and forgetfulness causing him to need minimal assistance of supervision.
- 6 points Client requires moderate assistance due to disorientation, mental or developmental disabilities or uncooperative behavior.
- 9 points Client requires maximal assistance due to confusion, incompetency, hostility or severe depression.

8. MOBILITY

- 0 points Client does not need any human assistance with mobility.
- 3 points Client needs assistance transferring to a wheelchair, getting out of a chair, or cannot climb stairs without assistance.
- 6 points Client requires assistance for all ambulation.

9 points Client is totally dependent on others.

9. DIETARY

0 points Client is on regular diet, can prepare own meals, and does not need assistance eating.

3 points Client requires 50% of meals to be prepared by others and needs encouragement or minimal supervision to eat.

6 points Client requires all meals to be prepared by others, needs to be fed by someone, or is on calculated diet for unstable condition.

9 points Client is unable to eat and requires tube feedings or parenteral fluids.

To be eligible for the Waiver, an individual must be assessed at 21 points or greater and have at least three of the following medical criteria and three functional limitations:

Medical Criteria:

1. Unusual support to maintain vital functions (oxygen, respiratory therapy, total parenteral nutrition, gastrostomy/NG feeding).
2. Continuous maintenance attention (positioning, feeding, cleaning, bathing, changing linens, and/or diapers).
3. Continual monitoring for skin breakdown and infections due to incontinence of bowel and/or bladder.
4. Private duty nursing provided continually in excess of 8 hours per day or 32 hours per week.
5. Continuous drug therapy.
6. Continuous or grand mal seizure requiring medication intervention.

Functional Criteria:

1. self-care
2. understanding and use of language
3. learning
4. mobility
5. self direction
6. capacity for independent living

- 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 process/tool used to determine waiver eligibility for this waiver is analogous to the initial level of care assessment performed for admission to the ICF/IID program in that the same criteria are assessed; however, point descriptions are more appropriate to the assessment of medically fragile persons with developmental disabilities.

- 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:

The BSHCN RN attends a quarterly home visit with each waiver participant to evaluate current needs. The Level of Care Determination form is completed every six (6) months. A comprehensive assessment is completed annually to determine care needs and medical necessity. The same process is used for initial evaluation and reevaluation.

- 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*):

The Program Manager maintains an electronic tracking system to assure that each participant is assessed every six (6) months. A report is provided monthly to the BSHCN RN and their immediate supervisor alerting staff as to the need for a timely reevaluation.

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

Original participant files are housed in the state regional offices in which the BSHCN RN who completes the assessments is domiciled. The Program Manager maintains a copy of the file. The files are stored in locked file cabinets, in a locked room for as long as the participant is receiving waiver services. Upon discharge of the participant the record is microfilmed and maintained indefinitely.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of level of care determinations prior to the receipt of services divided by the number of participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review by Program 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> ^ v </div>

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

Performance Measures

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

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

Performance Measure:

Number and percent of level of care determinations completed within 6 months of their last LOC evaluation divided by the number of participant records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> ^ v </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> ^ v </div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> ^ v </div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> ^ v </div>

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
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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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- 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 level of care determinations made by qualified staff divided by the number reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> State Medicaid Agency		
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of level of care decisions made in accordance with DHSS waiver requirements for the minimum level of care of 21 divided by the number of level of care decisions reviewed.

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

If 'Other' is selected, specify:

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

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

- 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.

While the current process meets the federal quality reporting requirements, MHD and DHSS will continue to research methods to enhance reporting capabilities. Once improvements are identified, the state will include this information on the CMS-372 report.

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 Program Manager reviews all Level of Care Determinations to assure that eligibility is met for initial enrollment and subsequent reevaluations. The Program Manager and/or designee, contact the BSHCN RN by email notification. The email notification identifies the deficiency and states the corrective action needed as well as the date the deficiency was identified, the date staff was notified, and the date of the corrective action was received by Program Manager. A copy of the correction is required for Central Office Records. The Program Manager tracts and trends this data and identifies if system changes are needed to maintain compliance with the waiver. The Program Manager communicates system changes to BSHCN staff as needed through regional staff meetings, and individual consults by telephone. System changes are reported to MHD during quarterly meetings and as needed.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

c. Timelines

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

☒ No

☐ Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The Client Choice statement is explained and discussed by the BSHCN RN with the participant and/or responsible party annually. The participant/responsible party is required to sign the form. All possible choices under Medically Fragile Adult Waiver are discussed. The participant and/or responsible party is given a choice of waiver services or services through an ICF/IID. The results of the assessment are discussed and the participant and/or responsible party participates in the development of a plan for services.

- 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.

Original participant records are housed in the state regional offices where the BSHCN RN is domiciled. The Program Manager maintains a copy of the file in the Central Office. The files are stored in locked file cabinets, in a locked room for as long as the participant is receiving waiver services. Upon discharge of the participant, the record is microfilmed and maintained indefinitely in the Central Office.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

It is the policy of the Department of Health and Senior Services (DHSS) to provide services on a nondiscriminatory basis based on national origin, race, sex, age, disability, color, religion or genetic information. Language barriers may interfere with the provision of services to consumers, leading to misunderstandings and impacting program effectiveness. Effective language services are put in place to help prevent these problems. All Department of Health and Senior Services employees and programs must utilize the State of Missouri's contract for providing interpretation and translation services. Guidance and information on the current contract is always available through the Office of Administration's web site.

POLICY:

I. PURPOSE:

It is the policy of the Department of Health and Senior Services (DHSS) to provide services on a nondiscriminatory basis based on national origin, race, sex, age, disability, color, religion or genetic information.

Language barriers may interfere with the provision of services to clients, leading to misunderstandings and impacting program effectiveness. Effective language services can help prevent these problems.

II. POLICY:

It is the intent of DHSS to:

- establish systems and procedures for the provision of services to any Limited English Proficiency (LEP) individual, particularly those who cannot communicate in spoken or written English;
- improve customer relations between DHSS and the people we serve;

- assure quality translation and interpretation services by obtaining feedback on the performance of translators and interpreters; and
- provide technical support to all DHSS programs.

III. DEFINITIONS

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

INTERPRETATION: Spoken transfer and understanding of a message from one language to another.

TRANSLATION: Written transfer and understanding of a message.

LIMITED ENGLISH PROFICIENCY (LEP) INDIVIDUAL: An individual whose primary language is not English and who cannot speak, read, write or understand the English language at the level necessary for effective communication.

METHODS OF ADMINISTRATION: Document signed by DHSS and provided to the U.S. Department of Health and Human Services (USDHHS) specifying methods DHSS will use to implement and assure compliance with Title VI of the Civil Rights Act of 1964 as amended (42 USC 2000d et seq); the Rehabilitation Act of 1973 (29USC 794), hereinafter referred to as Section 504; and the regulations issued there under by USDHHS (45 CFR Parts 80 and 84). It is essential to communicate information in a language other than English when and as required by federal regulations (see Administrative Manual Section 3.2).

IV. COMPONENTS:

A. Responsibilities:

1. All DHSS employees and programs shall utilize the state contract for providing interpretation and translation services. Guidance and information on what contract is currently being used by DHSS will be available through the Office of Human Resources or obtained through the contract search listing available on the Office of Administration's website.
2. All DHSS employees and programs will make reasonable efforts to offer interpretation and translation services when contact has been made with an individual of limited English proficiency. Contact should be recorded by the employee and the LEP Data Form can be used for convenience in recording said contact. A copy of the recording should be kept in the client's work file.
3. Each DHSS program will determine which materials and forms used by the public will be translated based on an assessment of the population in the services area.
4. Translation materials shall be linguistically and culturally appropriate to the client population.
5. DHSS will strive to provide visual and audio information in the appropriate language to LEP clients. Medically or legally complex materials may be contracted with a vendor for translation.
6. DHSS programs having state or federal funding cannot discriminate in the provision of services under Title VI. The Missouri Constitution, Article 1, Section 34 of the Bill of Rights, which states English to be the office language in the state, does not affect Title VI expectations for provision of services.

B. Contracts for Translation or Interpretation:

If vendors are contracted to provide interpretive services and/or perform the translation of materials to other languages, the program will be responsible for associated costs.

C. Contractors:

1. The contractors shall comply with all applicable provisions of the Civil Rights Act (45 CFR 80), the Rehabilitation Act of 1973 (45 CFR 84), and all other federal and state laws and regulations relating to nondiscrimination. The contractors shall assure that no person eligible for services shall on the ground of race, color, religion, national origin (this includes individuals of limited English proficiency), sex, disability, veteran status, age or genetic information be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination for any service provided by the contract. The contractors shall, within resources available, ensure minority health issues are addressed in the delivery of services where disparities in health status exist between minority and majority Missourians.

D. Clients of DHSS:

1. No client, applicant or their representative will be required to provide or pay for the services of a translator or interpreter.
2. For LEP clients, DHSS employees will identify and document on client records the primary language/dialect of the client and need for translation or interpretation services.
3. A family member or friend may be used as an interpreter if this is requested by the client and the use of such a person would not compromise the effectiveness of services or violate the client's confidentiality, and the client is advised that a free interpreter is available. The family member or friend must be 18 years of age or older.

- E. Responsibility for coordination of this policy is assigned to the DHSS Office of Human Resources.

Appendix C: Participant Services

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

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

Service Type	Service		
Extended State Plan Service	Waiver Attendant Care		
Other Service	Private Duty Nursing		
Other Service	Specialized Medical Supplies		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service 

Service Title:

Waiver Attendant Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:



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):

Waiver Attendant Care provides hands-on care with ADLs, of both a supportive and health-related nature, specific to the needs of a medically fragile participant. Supportive services are those which substitute for the absence, loss, diminution or impairment of a physical or cognitive function. (bathing, dressing, toileting, transferring, maintaining continence, feeding, personal hygiene, laundry, meal preparation). Housekeeping activities are solely for the participant and incidental to the performance of care, but may be furnished as part of this activity.

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

Waiver Attendant Care is above and beyond the limitations for State plan Personal Care. State plan Personal Care services will be utilized for care required in the home until exhausted. Waiver Attendant Care services may be utilized for care in the home and outside the home in the performance of normal life activities by waiver participants when medically necessary. The scope and nature of these services do not differ from State plan Personal Care services with the exception that Waiver Attendant Care can be provided outside the home. The provider qualifications specified under the State plan apply.

This service may not include skilled or nursing care.

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

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

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Providers

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Waiver Attendant Care

Provider Category:

Agency 

Provider Type:

Personal Care Providers

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Personal Care provider contracted with Missouri Medicaid Audit & Compliance and enrolled with MO HealthNet.

Personal care attendants must meet the following qualifications:

1. Be at least eighteen (18) years of age;
2. Be able to read, write and follow directions; and
3. Have at least six months paid work experience as an agency homemaker, nurse aide, maid or household worker, or at least one year of experience in caring for children or for sick or aged individuals. Successful completion of formal training in the nursing arts, such as a nursing aide or home health aide, may be substituted for the qualifying experience.
4. If the personal care attendant is providing advanced personal care, the aide must meet the criteria above to provide basic personal care and must meet the following additional criteria:
 - a) Be an LPN or a certified nurse assistant;
 - b) Be a competency evaluated home health aide having completed both written demonstration

portions of the test required by the Missouri Department of Health and Senior Services and 42 CFR 484.36; or

c) Have successfully worked for the personal care provider agency for a minimum of three consecutive months while working at least fifteen hours per week as an in-home aide that has received personal care training.

Advanced personal care tasks include but are not limited to routine personal care (changing bags, and soap and water hygiene around ostomy or catheter site) for persons with ostomies (including tracheostomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling, and suprapubic catheters; removal of external catheters, inspect skin and reapplication of same; administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (pre-packaged only) for participants without contraindicating rectal or intestinal conditions; apply medicated (prescription) lotions or ointments, and dry, non-sterile dressing to unbroken skin; use of a lift for transfers; manually assist with oral medications which are set up by a registered or licensed practical nurse; provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology; and apply non-sterile dressings to superficial skin breaks or abrasions as directed by a registered or licensed practical nurse.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Missouri Medicaid Audit & Compliance

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service 

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

Service Title:

Private Duty Nursing

HCBS Taxonomy:

Category 1:

Sub-Category 1:



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):

Individual and continuous care (in contrast to part time or intermittent care) provided by licensed or registered nurses within the scope of State law. The private duty nurse may train participants in the use of specialized medical supplies.

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

A maximum of 70 hours per week of Private Duty Nursing may be authorized per participant. Exceptions above the 70 hour per week cap may be authorized on a case by case basis by the Program Manager.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Duty Nursing providers

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Private Duty Nursing providers

Provider Qualifications**License (specify):**

State Home Health Agency 197.400-475RSMo

Certificate (specify):

Medicare Home Health Agency

Other Standard (specify):

Written proposal which specifies how provider meets regulatory requirements to provide Private Duty Nursing under 13 CSR 70-95.010

Verification of Provider Qualifications**Entity Responsible for Verification:**

Missouri Medicaid Audit and Compliance

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service 

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

Service Title:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:

Sub-Category 1:



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 supplies as specified in the plan of care, includes items which are not of direct medical benefit or remedial benefit to the individual. All items shall meet applicable standards of manufacture and design.

Examples of covered items include but are not limited to briefs, under-pads, gloves, tracheostomy collars, tracheostomy care kits; Foley indwelling and external catheters; gastrostomy tubes, Mickey Buttons; IV supplies; wound dressing supplies; ventilator supplies; oxygen masks; tubing.

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

Specialized medical supplies are not a routine covered service for adults under the Medicaid state plan. Before supplies are authorized under the waiver, there must be a denial from the MO HealthNet Exceptions unit. All supplies are prior authorized by BSHCN.

Service Delivery Method (check each that applies):

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment companies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Supplies

Provider Category:

Agency 

Provider Type:

Durable Medical Equipment companies

Provider Qualifications

License (specify):

Certificate (specify):

Medicare certification

Other Standard (specify):

Enrolled with MO HealthNet

Verification of Provider Qualifications

Entity Responsible for Verification:

Missouri Medicaid Audit & Compliance

Frequency of Verification:

At the time of enrollment; prior to payment of service

Appendix C: Participant Services

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

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

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

Check each that applies:

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

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

Department of Health and Senior Services, Bureau of Special Health Care Needs

Appendix C: Participant Services

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

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

- ☐ **No. Criminal history and/or background investigations are not required.**
- ☒ **Yes. Criminal history and/or background investigations are required.**

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

All positions that have contact with the enrolled participant require a Missouri background investigation through the Department of Health and Senior Services. These background investigations are completed by the provider agency on their employees.

Providers are responsible for requesting state criminal/background investigations on staff that provide direct care to waiver eligible participants prior to employment. Providers request these investigations through the Family Care Safety Registry which helps protect participants by compiling and providing access to background information. The Registry accesses the following background information from Missouri Data ONLY, and through the following cooperating state agencies:

- State criminal background records and the Sex Offender Registry information maintained by the Missouri State Highway Patrol
- Child abuse/neglect records, foster parent licensing records maintained by the Missouri Department of Social Services
- The EDL and child-care facility licensing records maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health

Missouri Medicaid Audit and Compliance (MMAC) unit is responsible for monitoring Providers to assure that background investigations are conducted as required by statute and regulation.

- 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):

All positions, that have contact with the enrolled participant require a Missouri background investigation through the Department of Health and Senior Services. These background investigations are completed by the provider agency on their employees. The Missouri Medicaid Audit and Compliance unit conducts periodic monitoring of providers and verifies background checks have been completed.

The Employee Disqualification List is maintained by the Department of Health and Senior Services and

quarterly checks on each employee are required. The Family Care Safety Registry is also maintained by the Department of Health and Senior Services and is required to be checked prior to employment. State Statute RsMO 660.315 and 660.317

Providers are required to perform abuse registry screening on all staff (all nurses, personal care attendants) that will be providing direct care services to waiver participants. Any potential employee listed on the Employee Disqualification List (EDL) is deemed ineligible for employment. The EDL is maintained by the Department of Senior Services. Screenings against the EDL can be handled through the Family Care Safety Registry.

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

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

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

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

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

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

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

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

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

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

- ☐ **Other policy.**

Specify:

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

Interested providers contact Missouri Medicaid Audit and Compliance Provider Enrollment Unit. Any provider who meets provider qualifications is allowed to enroll. Specific criteria regarding programs and provider enrollment requirements are available to all individuals through the MHD web site at <http://dss.mo.gov/mhd/index.htm>. MO HealthNet enrolled Home Health, Private Duty Nursing and Personal Care Program providers are required to complete an addendum and submit it to MMAC, Provider Enrollment Unit. There are no established time frames for enrollment of new providers, but the process normally takes approximately four (4) to six (6) weeks once a complete application is received by MMAC, Provider Enrollment Unit.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Performance Measure:

Number and percent of new provider applications for which the provider obtained appropriate licensure/certification in accordance with state law and waiver provider qualifications prior to service provision divided by total number of new provider applications.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver providers continuing to meet applicable licensure certification requirements divided by the number of waiver providers enrolled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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/non-certified waiver providers with a valid participation agreement with DHSS divided by the number of waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of non-licensed/non-certified waiver provider applicants who meet initial waiver provider qualifications divided by the total number of approved provider applicants.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance

Responsible Party for data	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

collection/generation (check each that applies):		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 new waiver providers that have someone on staff that has attended and passed provider designated manager certification divided by total number of new waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of providers submitting documentation that training requirements for direct care staff were met divided by the number of providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance, Provider Contracts Report

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify:	
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

The Missouri Medicaid Audit and Compliance (MMAC), a newly reorganized section of the Department of Social Services, will continue to provide oversight of the providers of waiver services. Not only will they continue to audit provider agencies, they will also audit the qualification of all direct care staff of the agencies, including the Registered Nurses and attendant care workers.

While the current process meets the federal quality reporting requirements, MHD and DHSS will continue to research methods to enhance reporting capabilities. Once improvements are identified, the state will include this information on the CMS-372 report.

b. Methods for Remediation/Fixing Individual Problems

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

Missouri Medicaid Audit and Compliance (MMAC) notifies the provider in writing immediately when problems are discovered. MMAC forwards a copy of the notification letter to MHD and DHSS when actions are taken against a provider. Remediation may include recoupment of provider payments or termination of provider enrollment. MMAC monitors the provider for compliance. Information is provided to MHD and DHSS regarding the problems identified, remediation actions required and changes made by the provider to come into compliance. This information is tracked and trended to ensure problems are corrected.

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

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.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Care

- 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:*

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.

- A Plan of Care shall be developed from the information obtained during the assessment process. This plan is a guideline for how services shall be provided to meet the needs of the participant and/or responsible party. Requirements for plan development include a time line for completion, notice and arrangements for meeting to develop the plan, and team members to be included.
- The participant and/or responsible party chooses whom (s)he wants to participate as a member of the service plan development team.
- The Plan of Care shall be developed in cooperation with the participant and/or responsible party identifies the following:
 - o Concerns, priorities and resources of the participant and/or responsible party
 - o Outcomes or changes the participant and/or responsible party wants to occur
 - o Services needed to address the identified outcomes
 - o Method, duration and location of services
 - o Service providers
 - o Funding resources to cover the cost of the services
 - o Effective date for the initiation of services

A home visit shall be made to develop the Plan of Care. The complexity of the plan depends on the needs of the participant and/or responsible party and service requirements.

- o Schedule a contact with the participant and/or responsible party to explain the service coordination process and to develop the Service Plan.
- o Promote participation in the development of the plan. Encourage the participant and/or responsible party to

discuss their concerns and priorities.

- o Assist the participant and/or responsible party in identifying their resources. Resources include personal strengths, weaknesses and preferences, community/family support, coping skills, access to transportation and financial resources such as private insurance, Medicaid/Medicare or SSI eligibility and identifies who controls the participant's finances.
- o Identify other agencies/providers who are involved in providing services to the participant and/or responsible party. Collaboration and contact with other providers is encouraged. An Authorization for Disclosure of Consumer Medical/Health Information shall be obtained to allow for exchange of information.
- o Provide information about other resources and help the participant and/or responsible party to identify resources that might be helpful.
- o Help the participant and/or responsible party to identify and prioritize their goals or outcomes. An outcome is defined as a statement of the goals/changes a participant and/or responsible party wants to see occur for their family member or themselves. Help the participant and/or responsible party to identify the services needed to meet the identified outcomes.
- o Create opportunities for the participant and/or responsible party to make decisions regarding services. Determine who shall provide the service, how often the service is needed and where the service shall be provided. Identify the funding source for payment of the service and the date the service is to begin.
- o Provide the participant/family with information about obtaining the identified services. This includes making sure they have the contact names, addresses/telephone numbers or referral information for the agency.
- o Provide a copy of the Rights and Responsibilities of the participant and/or responsible party, including the process to request a Fair Hearing, and the service coordinator.
- o Plan for future contact.

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 Plan of Care is developed every six (6) months by the BSHCN RN, family, health care team members and anyone else the family requests.
- B) The BSHCN RN completes a Service Coordination Assessment annually and the Client Assessment Form, Level of Care Determination and Prior Authorization forms every 6 months. All of these documents comprise the Plan of Care that is developed using input from the participant and/or responsible party, provider documentation and medical records.
- C) The Client Choice Statement is discussed, as are services and provider options. The Private Duty Nursing Acceptance Form is also completed. This form is an informational form that defines private duty nursing, the role of the BSHCN, the responsibility of the responsible party and the circumstances under which private duty nursing services are not covered. It must be signed by the participant or responsible party to acknowledge receipt of information and discussion regarding the requirements of Private Duty Nursing.
- D) Through discussion and participation the participant and/or responsible party offer input and voice strength, concerns, preferences, priorities and goals during the development of the plan.
- E) The BSHCN RN is responsible for coordination of services. Qualified providers are identified through availability and participant and/or responsible party choice.
- F) The BSHCN RN, along with the participant and/or responsible party, is responsible for implementation and compliance with the Plan of Care. This is discussed during assessment, evaluation and care plan development.
- G) The Plan of Care is reviewed every three months, revised/updated every six months and re-written annually and updated as needed. The participant and/or responsible party is encouraged to contact the BSHCN RN when changes in the plan are needed or they have concerns regarding their care and/or services.

Reference Appendix D-1 c. for additional information.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

1. A safety assessment of risk factors for abuse or neglect is completed.

The BSHCN RN completes a service coordination assessment annually, which includes discussion of risk factors related to financial well being including who controls the participant's finances, communication needs, availability of health care resources, physical health, mobility, ability to perform ADLs, nutritional needs, social and emotional health, cognitive abilities, educational/vocational needs, family support systems, cultural needs, safety issues and satisfaction of care provided. Risk factors are monitored quarterly and reviewed every six months.

2. Client Assessment of medical needs.

The BSHCN RN assesses the availability of medical care, assists in securing a primary care physician and assists with specialty referrals. A review of medications and nursing assessment of general health status is completed.

3. Review of medical records/documentation.

The BSHCN RN requests and reviews medical reports as needed to identify potential risks and needs. The BSHCN RN reviews the nursing notes made by the provider to assess for additional needs and appropriate service delivery.

4. An Emergency Preparedness Plan is discussed.

Emergency preparedness materials are discussed with the participant and/or responsible party and assistance offered to complete an emergency plan. The BSHCN RN reviews the plan with the participant and/or responsible party to ensure the safety of the participant on an ongoing basis.

5. Backup caregivers and plan are identified and documented.

Each participant and/or responsible party is required to identify a back-up caregiver plan in the event a provider fails to fulfill a shift. Plans begin with the participant/responsible party identifying back-up caregivers who are trained in the care of the waiver participant and that will be available to provide care in the event that provider staff fails to fulfill a shift. Plans include contacting the provider agency, and activating the back-up caregiver plan to provide care until replacement staff arrives. The back-up plan ensures the participant is not left without appropriate care.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A list of qualified providers is available to participants through the BSHCN RN and is also available through the MHD website <http://dss.mo.gov/mhd/index.htm>. Participants and/or responsible party are asked to choose their service provider and the Client Choice Statement is completed.

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):

Each Plan of Care is reviewed by the Program Manager and is available to the MO HealthNet Division. A statistically valid sample using the RaoSoft sample size calculator is reviewed annually by the MO HealthNet

Division. This review ensures participants receiving waived services have a Plan of Care in effect for the period of time services are provided, and that services are provided in accordance with the Plan of Care.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ☐ Every three months or more frequently when necessary
☒ Every six months or more frequently when necessary
☐ Every twelve months or more frequently when necessary
☐ Other schedule

Specify the other schedule:

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

- ☐ Medicaid agency
☒ Operating agency
☐ Case manager
☐ Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

a. Monitoring and implementation of the Plan of Care and participant health and welfare is the responsibility of the BSHCN RN and the provider agency. The provider agency monitors the provision of services by their RN/LPN to ensure provision of services in accordance with physician's orders and communicates with the participant's physician and/or the BSHCN RN and/or Regional Coordinator (RC) as necessary.

b-c. The Plan of Care and provision of services are monitored through monthly contact by the BSHCN RN with the participant and/or responsible party, caregiver and/or provider. An in-home visit is performed every three (3) months with a review of the Plan of Care. The plan is revised/updated every six (6) months or as needed and rewritten annually.

Monitoring and follow-up methods to assure health and welfare of the participant include but are not limited to the following:

- Participants have access to waiver services identified in the Plan of Care by documenting referrals made, accepted and attempts to secure difficult-to-obtain services.
- Services meet the needs of the participant by documentation of stability of health (lack of hospitalizations, Dr. visits, etc.) and reported participant satisfaction. Satisfaction surveys are conducted annually.
- Back-up plans are effective by evidence that care was safely and adequately provided as reported by the participant

and/or responsible party in the absence of the provider agency.

- Participant health and welfare is assured by evidence that the participant is stable and there have been no reports of abuse/neglect or exploitation.
- Participants and/or responsible party exercise free choice of providers. The Client Choice Statement is explained and discussed annually with the participant and/or responsible party. A list of qualified providers is available as needed or requested by the participant and/or responsible party or to explore other provider options.
- Participants have access to non-waiver services. When needs are identified that are not funded by the waiver, appropriate referrals are made. For example, a referral may be made to local agencies that provide funding for various needs such as building a ramp, home repairs, non-medical transportation, etc.
- Services are furnished in accordance with the Plan of Care by reviewing nursing notes and the monthly monitoring log that is required to be submitted by the provider agency. The log lists services authorized and delivered, and requires a reason for services not delivered in accordance with the plan.
- The program manager reviews and approves 100% of all participants Plan's of Care.

In addition, unusual or unexpected events, concerns and complaints are reported to the Program Manager. The Program Manager, with the BSHCN RN, provides effective follow-up within one (1) working day of the notification and resolution no later than ten (10) working days. A confidential event report is completed by the BSHCN staff member first aware of the situation. The BSHCN RN, RC or Program Manager takes steps and/or makes recommendations toward resolving the issue.

The State Medicaid Agency annually reviews a statistically valid sample of participant records. Participant records are reviewed for compliance with applicable federal laws pertaining to Plan of Care, Level of Care, Client Choice, as well as health and welfare requirements. Annual reports are tracked and trended to identify any problems and determine needed remediation. BSHCN provides follow-up to MO HealthNet on the findings and puts policy and or procedures in place as needed for remediation.

b. Monitoring Safeguards. Select one:

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of service plans with assessed needs identified and addressed divided by the number of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- 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 service plans developed in accordance with waiver requirements and DHSS policy and procedure divided by the number of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

<input type="text"/>		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 service plans that were reviewed and revised, as warranted, on or before waiver participant's annual review date divided by the number of service plans reviewed.

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

If 'Other' is selected, specify:

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

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

Performance Measure:

Number and percent of service plans that were reviewed and revised to address changing needs of the participant divided by the number of service plans requiring revision due to changing 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- 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 service plans reviewed that meet expected delivery dates divided by number of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

<input type="text"/>		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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 waiver participant records with an appropriately completed and signed Client Choice statement that specifies choice was offered

between institutional care and waiver services divided by the number of records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number and percentage of service plans reviewed that indicate the participant/responsible party was offered a choice of service providers divided by the number of service plans reviewed.

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

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- 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.

While the current process meets the federal quality reporting requirements, MHD and DHSS will continue to research methods to enhance reporting capabilities. Once improvements are identified, the state will include this information on the CMS-372 report.

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.

BSHCN addresses any issues related to the Plan of Care in their monthly record reviews immediately with the BSHCN RN. The BSHCN RN is required to take appropriate corrective action. Follow-up to ensure the problem was remediated is done by the Program Manager. Individual problems are included in the annual waiver report.

The BSHCN RN responds to the Program Manager's request to resolve the individual problem by completing the corrective action and submitting the correction to the Regional Coordinator and the Program Manager. In collaboration with the Regional Coordinator and the Program Manager, the BSHCN RN assures steps identified in the corrective action are implemented. Problems are reviewed with individual staff by the Regional Coordinator and the Program Manager. Changes to processes are discussed and implemented during bi-annual Statewide Meetings with BSHCN staff.

Individual problems are addressed as they are discovered. Program Manager/designee contacts the BSHCN staff by email notification which identifies the deficiency, states the corrective action required. The Program Manager maintains a "Remediation LOG" which identifies the DCN, BSHCN RN, deficiency, corrective action needed, date discovered, date remediated and the date that a copy of the correction was received by the Program Manager.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

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

☒ **No**

☐ **Yes**

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

Appendix E: Participant Direction of Services

Applicability (*from Application Section 3, Components of the Waiver Request*):

- ☐ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ☒ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (*select one*):

- ☐ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ☐ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

During the assessment process, the BSHCN RN provides each participant with a Client Choice Statement and a list of qualified providers. The participant and/or responsible parties choice of a qualified provider is documented. The Client Choice Statement includes the following information regarding appeal rights:

"I understand if my services are reduced, closed or denied, I will be advised in writing. I will have the right to appeal the decision as specified in 42 Code of Federal Regulations 431.200-250. A hearing may be requested within ninety (90) days of the date of the denial letter. To request a hearing I should contact the Participant Services Unit by letter, telephone or in person. A hearing will then be scheduled for me and I will be notified of the time and place of the hearing. If a hearing is requested within ten (10) days of the date of the letter, the services will continue pending the hearing decision. I understand if the decision is made to proceed with the reduction, termination or denial of services, the State has the right to take back the payment of any services that were asked to be continued."

The address and phone number for MO HealthNet Division Participant Services is provided in the letter.

When services are reduced, terminated or denied, the participant is given written notification by the BSHCN RN that includes their appeal rights, process to request a hearing and the process for maintaining services.

The participant reviews and signs the Client Choice Statement annually and receives a copy. The BSHCN RN maintains a copy in the client record.

The participant/responsible party is given verbal and written information in the Rights and Responsibilities form, the hearing process is explained by the BSHCN RN and the Rights and Responsibilities form is signed by the participant/responsible party upon enrollment and annually. Anytime the participant/responsible party does not agree when services are changed, reduced or denied, the BSHCN RN explains the appeal process and a letter is mailed to the participant/responsible party stated the changes, reduction or denial, and an effective date. The letter also provides instruction on how to appeal a decision and an address and phone contact for the Participant Hearings Unit. The BSHCN RN is available to explain the appeals hearing process anytime the participant/responsible party has questions or concerns or has difficulty in notifying the hearings unit.

The Client Choice Statement includes the rights to appeal. The process is verbally explained to the participant/responsible party prior to obtaining the participant/responsible party signature and date. This form is explained and completed annually.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
- ☒ **No. This Appendix does not apply**
- ☐ **Yes. The State operates an additional dispute resolution process**
- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

☒ **No. This Appendix does not apply**

- ☒ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- ☒ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

- ☐ **No. This Appendix does not apply** (*do not complete Items b through e*)

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

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

Critical incidents include abuse (physical, sexual, or emotional; exploitation; and misappropriation of funds/property) and neglect (self- or by others). Missouri statutes include a universal mandated reporting, stating that any person having reasonable cause to suspect that an eligible adult is experiencing abuse or neglect and in need of protective services shall report such information to the Department of Health and Senior Services (DHSS). This universal mandate has no statutory penalties for not reporting and contains no immunity for those who do report. (192.2410, RSMo) Missouri statutes also include specific language in certain sections that mandate various entities to report possible abuse and/or neglect or cause a report of possible abuse and/or neglect to be made to DHSS. The entities that are mandated to report are: adult day care worker; chiropractor; Christian Science practitioner; coroner; dentist; embalmer; employee of the Departments of Social Services, Mental Health, or Health and Senior Services; employee of a local area agency on aging or an organized area agency on aging program; funeral director; home health agency or home health agency employee; hospital and clinic personnel engaged in examination, care, or treatment of persons; in-home services owner, provider, operator, or employee; law enforcement officer; long-term care facility administrator or employee; medical examiner; medical resident or intern; mental health professional; minister; nurse; nurse practitioner; optometrist; other health practitioner; peace officer; pharmacist; physical therapist; physician; physician's assistant; podiatrist; probation or parole officer; psychologist; consumer-directed services provider (this covers IL Waiver providers); personal care attendant; or social worker. When any of these entities has reasonable cause to believe that a participant has been abused or neglected

are to IMMEDIATELY report or cause a report to be made to the department. These mandated reporters who fail to report or cause a report to be made to DHSS within a reasonable time after the act of abuse or neglect is guilty of a Class A misdemeanor. (198.070 and 192.2475,RSMo)The methods of reporting include calling DHSS staff or the Central Registry Unit 800# (this number is promoted on DHSS public information, brochure, posters and website), written correspondence with DHSS or through the 'Ask Us' function on DHSS' website. Reports are typically logged through the Central Registry Unit, as it is often the first point of contact for the public. However, reports are also logged at field offices when calls are taken directly at those locations.

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

Each waiver participant is provided with a copy of the Expectation for In-Home Services authorized by Special Health Care Needs document upon initial assessment and quarterly and annually, by the BSHCN RN. This document includes definitions of abuse, neglect, and exploitation and examples to assist the BSHCN RN to teach the participant and or responsible party to identify abuse, neglect, exploitation, the use of inappropriate restraints, seclusion or restrictive interventions. Contact information for the BSHCN RN and the following statement is included: "If you feel your rights have been violated or if you or your family have been abused, neglected, or exploited, contact: Elder Abuse or Neglect Hotline 1-800-392-0120."

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

The Department of Health and Senior Services (DHSS) is the mandated adult protective services agency in Missouri. Statute 192.2415 RSMo defines the investigatory authority of DHSS as limited to eligible adults with a protective service need. DHSS/DSDS staff shall investigate and offer protective services to all eligible adults when deemed appropriate. This shall include: 1) adults age 60 years or older who are unable to protect their own interests or adequately perform or obtain services which are necessary to meet their essential human needs, and 2) adults with disabilities between the ages of 18 and 59 who are unable to protect their own interests or adequately perform or obtain services which are necessary to meet their essential human needs. Reports may be received that would not fall within the scope of DHSS' authority but may be appropriately referred to another agency for assistance. All reports, regardless of where placed, are forwarded to the DSIDS Central Registry Unit to be registered into the Mo Case Compass and Aspen Complaints/Incidents Tracking System (ACTS) data base system. The following is applicable to waiver participants receiving services in their own home:

Preliminary classification of reports is based on information received from the reporter at the point of intake. Classification is based on the level of harm or risk to the reported adult, combined with the reported need to gather evidence. Class I reports contain allegations, which if true, present either an imminent danger to the health, safety or welfare of an eligible adult or a substantial probability that death or serious physical harm will result. Class I reports involve situations of a crisis or acute nature which are currently occurring and require immediate intervention and/or investigation to gather critical evidence. (Reporters are directed to contact the local law enforcement agency on reports involving allegations of homicide or suicidal threats). Class II reports contain allegations of some form of abuse, neglect, or exploitation of an eligible adult but do not allege or imply a substantial probability of immediate harm or danger. Situations described in a Class II report do not require an immediate response. DHSS staff are responsible for the investigative process. Mo CaseCompass develops a baseline investigation plan which includes a standard set of Activities/Tasks for an investigation. The investigator can add additional activities/task as needed. The investigative plan is completed inside the MO CaseCompass system providing notifications and alerts to the investigator of required policy tasks and completion of investigation. 1) Review of the report and conducting background checks of the subjects of the report. 2) Development of an investigative plan, outlining the actions to be taken in accordance with the reported information The investigative plan will include the assessed need to involve medical professionals; the order of the interviews to be conducted, i.e., reporter, reported adult, witnesses and the alleged perpetrator; determination of which records or documents need to be obtained to (dis)prove the allegations in the report; evidence suggested in the report to be immediately obtainable which will assist in (dis)proving the allegations and determination of which agency or entity (if any) that needs to be contacted to co-investigate or provide support. 3) A thorough investigation is conducted obtaining all information necessary to determine whether the alleged abuse, neglect or exploitation actually occurred (or is occurring). The information is gathered and memorialized through documentation to properly preserve the evidence. 4) Evaluation, analysis, organizing and reviewing the information to determine if legal intervention or protective services is warranted. This shall include

further follow-up and resolution when there are discrepancies or inconsistencies, evaluating the risk of harm or injury to the reported adult and assessing the capacity of the reported adult and providing necessary interventions. 5) Completion of a summary and determining the investigative conclusion according to the information obtained during the investigation. This will include recording all contacts and activities related to the investigation in the case record. It will also include submitting a copy of the investigation and findings to the Division's Community Health Nurse Consultant if involves deteriorating health condition, local police, local prosecutor or DHSS Office of General Counsel when the information gathered substantiates the allegation. A copy of the report is also sent to the DHSS Employee Disqualification List staff when a referral to this list warrants consideration. 6) Policy requires that investigations are conducted and completed and findings/results entered into the Mo CaseCompass system within a ninety (90) day period. In response to Class I reports, a face-to-face must be made as soon as necessary or possible within the 24 hours following receipt of a report to ensure the safety and well being of a reported adult. The 24-hour period will begin at the time the information was received by DSDS. Investigations of Class II reports shall be initiated within a period not to exceed 48 hours after receipt of the report or by close of business the first working day after a weekend or holiday. Investigators shall conduct a face-to-face interview as soon as possible within a period not to exceed 7 calendar days from the receipt of the report. A waiver participant for whom an investigation is being conducted is involved in the investigation and the subsequent intervention process or plan on an ongoing basis. State statutes specifically, 192.2435, 192.2500 and 192.2505 RSMo prohibit DHSS from disclosing the investigative results/reports to anyone other than the participant/legal representative upon request, the Attorney General's office to perform that office's constitutional or statutory duties, the Department of Mental Health for residents placed through that Department to perform its constitutional or statutory duties, the appropriate law enforcement agency to perform its constitutional or statutory duties, or the Department of Social Services for individuals who receive MHD benefits to perform its constitutional or statutory duties.

The Program Manager reviews all Event Reports and provides consultation to the BSHCN staff regarding reporting and follow-up documentation. Events are reported to the Program Manager immediately upon notification that ANE has occurred or been alleged. BSHCN staff documents details on the Event Report and sends to the Programs Manager. BSHCN staff calls the Hotline to also inform them that BSHCN is providing services to the participant and is available to the CRU if needed, during the investigation. BSHCN staff requests that the Division of Senior and Disability Services (DSDS) staff notify BSHCN if the investigation of the event was/was not completed within the appropriate timeframe and if the investigation was closed within 60 days (per DSDS Policy). A revised Event Report indicating whether the timeframe for the investigation was/was not met is submitted to the Program Manager. The Program Manager maintains an Event Log and determines the number and percent of waiver participants who have had an Event Report that resulted in an investigation that was initiated within the Class I or Class II Investigation timeframe, divided by the number of records reviewed. BSHCN staff review individual problems that have occurred during the last face to face contact during a monthly telephone contact to identify if there has been a resolution of the problem; Subsequent Event Reports may be completed for problems not resolved, with additional contact to the CRU. Participants/families/representatives requesting results of investigations receive a letter within three days of their request. The letter states that their request has been received and records will be provided in approximately 45 days.

The Program Manager reviews all Death Notification forms and provides consultation to the BSHCN staff regarding follow-up documentation. Participant deaths are reported by BSHCN staff when they are notified of a participant death. This Death Notification form provides information about the date of death, place of death, cause of death (if known), how BSHCN was notified and other comments. The Program Manager maintains a mortality log. If there is a police investigation of the participant's death, the outcome of the investigation is added to the Death Notification form and the mortality log is updated with the results of the investigation.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DSDS is responsible for overseeing the operation of the incident management system. DSDS supervisors are required to read 100% of all third party perpetrator reports and 100% of all class I reports regarding imminent harm as well as periodic reviews of all other reports. (This applies to waiver participants receiving services in their own home.) Supervisor reviews are triggered based on criteria in the MO CaseCompass system. This supervisory review determines if the staff person conducting the investigation has followed policy and procedure during the investigation, has communicated with all the necessary parties, and has documented the investigation correctly. This oversight is conducted on an ongoing basis. The Supervisor, in an effort to assist in the on-going quality of the investigations will conference with staff on reports, read on-going records, and possibly attend on interviews with the

investigator. The Mo CaseCompass and Aspen Complaints/Incidents Tracking System (ACTS) database system is utilized to collect information on reports containing allegations of Abuse Neglect and/or Exploitation (ANE) and to track occurrence/reoccurrence of ANE by reported adult, alleged perpetrator, and the allegation(s). This system is accessible to all investigating staff and can be utilized in the investigation process to track how past similar allegations were handled. DSDS is mandated to provide protective services for eligible participants to help prevent future reports by reducing the cause of the abuse, neglect or exploitation through a variety of activities: financial/economic interventions, education, local community supports, in-home or consumer-directed services, use of the resources of other agencies/entities, and the periodic contacts required when an individual is placed under 'protective service' status with DHSS. Waiver participants that have been placed under 'protective service' status are identified along with the level of protective service needed. These levels are: -Indicative of a minimal but consistent need for protective intervention with the intent to reduce injury/harm by increasing support system and regular contacts to be made as needed to the support system and a minimum of one home visit every six months, or-Indicative of a moderate need for protective intervention with contacts to occur on a regular basis averaging at least twice per month and a minimum of one home visit every six months, or-Indicative of intense need for protective intervention with contacts to occur with and/or on the behalf of the participant weekly and a home visit monthly.

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

DSDS provides summary reports to the Medicaid Agency no less than annually.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

☒ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

BSHCN staff reviews documentation in the participant's file, specifically reviewing for unauthorized restraint and seclusion. Inappropriate use of restraints or seclusion, frequent hospitalizations or emergency care, or injuries of unknown origin will be reported to the DHSS Abuse and Neglect hotline if abuse, neglect or exploitation is suspected, as identified during monthly contacts and home visits.

BSHCN staff utilize a monthly contact template to assess areas of unmet needs; changes in medical status; unplanned physician visits, emergency care or hospitalizations; identifies unknown injuries; medication changes; mental health status; satisfaction with services; participant and/or responsible party reports a sense of security in the home and identifies concerns regarding provider staff or concerns with BSHCN staff. The participant and/or responsible party reports understanding of what constitutes abuse, neglect, exploitation, inappropriate use of restraints, seclusion and/or restrictive interventions and how to report.

☐ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

- ☒ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

All waiver services are performed in the participant's home or accompanying the participant in community activities. BSHCN staff make monthly phone contact with the participant and/or responsible party as well as a face to face visit every three (3) months. BSHCN staff reviews documentation in the participant's file, specifically reviewing for unauthorized restraint and seclusion. Possible inappropriate restrictive interventions will be documented and reported to the Central Registry Unit (CRU) at DHSS if abuse, neglect or exploitation is suspected.

- ☐ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- ☒ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

All waiver services are performed in the participant's home or accompanying the participant in community activities. These homes are owned/rented by the participant/caretaker. BSHCN staff make monthly phone contact with the participant and/or responsible party as well as a face to face visit every three (3) months. BSHCN staff reviews documentation in the participant's file, specifically reviewing for unauthorized restraint and seclusion. Possible incidents of seclusion will be documented and reported to the Central Registry Unit (CRU) at DHSS if abuse, neglect or exploitation is suspected.

- ☐ **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

- ☒ **No. This Appendix is not applicable** (do not complete the remaining items)
- ☐ **Yes. This Appendix applies** (complete the remaining items)

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

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

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

- ☐ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of records reviewed where the participant/responsible party was provided information on who to contact regarding complaints divided by the number of participant records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

		<input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of service plans with an adequate backup plan specified in their service plan divided by number of service plans reviewed.

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

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of records reviewed where the participant and/or family or legal guardian received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver divided by the number of participant records reviewed.

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

If 'Other' is selected, specify:

Responsible Party for data	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

collection/generation (check each that applies):		
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 Event Reports that resulted in an investigation that was initiated within required timeframes divided by number of Event Report investigations reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of investigations regarding unexplained deaths of waiver participants reviewed within required time frames. Numerator = Number of investigations regarding unexplained deaths of waiver participants reviewed within required time frames. Denominator = Number of unexplained death hotline investigations reviewed.

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

If 'Other' is selected, specify:

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

		<input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of hotline investigations that were effectively resolved within required time frames. Numerator = Number of waiver participants' hotline investigations effectively resolved within required time frames. Denominator = Number of hotline investigations reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

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

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

Performance Measure:

Number and percent of use of restrictive interventions that were appropriately reported. Numerator = Number of unauthorized use of restrictive interventions

appropriately reported. Denominator = Number of unauthorized use of restrictive interventions reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- d. **Sub-assurance:** The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

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

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

Performance Measure:

Number and percent of waiver providers maintaining compliance with healthcare standards as required by state regulation. Numerator = Number of waiver providers maintaining compliance with healthcare standards as required by state regulation. Denominator = Number of waiver providers reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.

While the current process meets the federal quality reporting requirements, MHD and DHSS will continue to research methods to enhance reporting capabilities. Once improvements are identified, the state will include this information on the CMS-372 report.

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 Program Manager addresses any issues with the BSHCN staff related to health, welfare and safety immediately. The Program Manager keeps a log of events. Follow-up to ensure the problem was remediated is done by the Program Manager. Individual problems are included in the annual waiver report.

The Program Manager reviews all Event Reports and provides consultation to the BSHCN staff regarding reporting and follow-up documentation. Events are reported to the Program Manager immediately upon notification that ANE has occurred or been alleged. BSHCN staff documents details on the Event Report and sends to the Programs Manager. BSHCN staff calls the Hotline to also inform them that BSHCN is providing services to the participant and is available to the CRU if needed, during the investigation. BSHCN staff requests that the Division of Senior and Disability Services (DSDS) staff notify BSHCN if the investigation of the event was/was not completed within the appropriate timeframe and if the investigation was closed within 60 days (per DSDS Policy). A revised Event Report indicating whether the timeframe for the investigation was/was not met is submitted to the Program Manager. The Program Manager maintains an

Event Log and determines the number and percent of waiver participants who have had an Event Report that resulted in an investigation that was initiated within the Class I or Class II Investigation timeframe, divided by the number of records reviewed. BSHCN staff review individual problems that have occurred during the last face to face contact during a monthly telephone contact to identify if there has been a resolution of the problem; Subsequent Event Reports may be completed for problems not resolved, with additional contact to the CRU.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

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

- ☒ **No**
☐ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

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

No less than annually MHD Program Operation staff and DHSS Program Oversight staff meet to discuss the Quality Improvement Strategy (QIS) described throughout the Medically Fragile Adult Waiver, AIDS Waiver, Aged and Disabled Waiver, and the Independent Living Waiver.

At this time, DHSS Program Oversight staff and MHD Program Operations staff jointly review the performance measures and analyze corresponding reports generated by both agencies. MHD and DHSS review the outcome of the reports to ensure they are meeting the assurances specified throughout the application and what, if any, action may be necessary for remediation and or system improvement. Systemic errors and trends are identified by MHD and DHSS based on the reports for each performance measure using the number and percent of compliance.

Recommendations for system change may come from either agency however MHD will approve any changes to the Quality Improvement Strategy specified in the waiver application. Any changes in the QIS in the waiver application are implemented and monitored, as appropriate. Any changes will be included on the next 372 report.

System improvement activities related to participant health, welfare, and safety are the first priority for MHD and DHSS staff. Additional priorities are established based on the number and percent of compliance specified in the waiver reports for the QIS in the waiver.

Although individual problems are remediated upon discovery, performance measures that are significantly lower than 100% may need to be addressed as a systemic issue. Implementation of system improvement will be a joint effort between DHSS and MHD. System change related to delegated activities will be the responsibility of DHSS and those activities that are not delegated will be the responsibility of MHD. Follow-up discussions related to system improvement activities may be discussed at quarterly meetings but will be discussed no less than annually.

Systemic issues may require follow-up reports, policy and or procedure changes, as well as staff and/or provider training

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

All reports are stratified by waiver.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

A quality improvement report is developed annually based on performance measure reports and at a minimum will identify the systemic issue, the proposed resolution, and the established time frame for implementation. Established timeframes from the annual report for remediation activities will be discussed and reviewed during quarterly meetings. The report will be updated as appropriate when systemic remediation activities have been completed. Effectiveness of system improvement activities will be monitored no less than annually at the QIS meeting based on new reports on the established performance measures. Significant systemic issues will be addressed by MHD and/or DHSS through increased reporting or monitoring as deemed necessary and appropriate.

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

The Home and Community Based Services Waiver Quality Management Strategy specified in the waiver are evaluated and updated no less than annually by MHD and DHSS. The process includes the review of performance measures, reports for performance measures and remediation activities resulting from discovery. Annually MHD and DHSS will determine if the QIS is providing the information and improvements necessary to meet the quality assurance performance measures as it relates to discovery, remediation and improvement activities. The committee will evaluate the QIS process annually to determine if the committee process is working. If the committee determines additional input is necessary, DHSS and MHD will request input from individuals involved in the authorization and/or delivery of waiver services. This could include providers and/or DHSS and MHD staff from other units within the Divisions.

Appendix 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. MO HealthNet does not require providers to perform independent audits annually.
- b. MO HealthNet uses a statistically valid random sample to identify waiver participant records for review annually. The provider billings/payments for those participants identified through these sampling are reviewed against the provider records to determine if there is documentation to support the claims paid through the MMIS system. Agency administrative records are reviewed to determine agency compliance with program requirements. Providers are given written notice of deficiencies and overpayments. This notice requires a provider to send a corrective action plan. Overpayments are recouped based on the findings of the review.
- c. The agency responsible for conducting the audit program is the Department of Social Services, Missouri Medicaid Audit and Compliance. The Missouri State Auditor's Office is responsible for conducting the State's independent audit annually in accordance with the Single Audit Act of 1996 (P.L. 104-146).

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

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of waiver claims paid that were prior authorized divided by the number of waiver claims paid.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

Performance Measure:

Number and percent of waiver claims paid for services that are included in the approved waiver divided by the number of waiver claims paid.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- 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 rates that remain consistent with the approved rate methodology throughout the five year waiver cycle. Numerator = Number of rates that remained consistent with the rate methodology. Denominator = Total number of approved rates.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
- State financial oversight exists to assure claims are coded and paid in accordance with the reimbursement methodology in the approved waiver. Claims payment issues are the responsibility of MHD. MHD works to resolve payment issues as they are identified by MHD and or DHSS. Remediation occurs through changes in policy, procedure or MMIS system edits or audits.

MHD staff run reports annually to ensure payments are made accurately and any corrections made to the system are operational.

When payment issues are identified, MHD staff generate a System Problem Assistance Request to the state fiscal agent requesting information as to why a claim is not paying correctly. The state fiscal agent reviews the claims data to determine why a claim is not processing correctly. Once the problem is identified, the fiscal agent makes corrections to fix the problem. MHD staff review test documentation to ensure that the actions taken by the fiscal agent remedy the situation. Once the problem has been corrected, MHD staff monitor to ensure future claims pay correctly.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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).

Current rates are established through appropriations by the Missouri General Assembly.

Rates for waiver attendant care, private duty nursing and specialized medical supplies in this waiver are based on historic data regarding the sufficiency of payment to attract a provider network capable of meeting the needs of waiver participants. Requests for funding are made to the General Assembly by MHD and DHSS to cover the cost of waiver services. In addition to requests by the state, funding requests are made to the General Assembly by the provider industry.

Rates are determined jointly by MHD and DHSS.

Public comments are garnered during the legislative session in response to state agency budgets.

Information regarding payment rates are available upon request of the BSHCN RN, through the MHD Participant Services Unit or online at the MHD website. Requests may be made in writing to MHD or DHSS, by email to ASK MHD, or by phone call to the MHD Participant Services Unit.

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

All services provided under this Waiver Program are prior authorized by the Bureau of Special Health Care Needs RNs, subject to approval by the MO HealthNet Division. The prior authorization is forwarded to the MO HealthNet Fiscal Agent. Providers of services bill claims for services directly to the MO HealthNet Fiscal Agent for claims processing. All claims are processed through MMIS. Claims are checked against services prior authorized. Only authorized services are paid. Payment is made directly to the provider of service.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

- ☒ No. State or local government agencies do not certify expenditures for waiver services.
☐ Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

- ☐ Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

☒ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All claims are processed through MMIS. MO HealthNet eligibility and prior authorization of waiver services is verified prior to claims payment. All services included in the participants approved service plan are prior authorized. If an individual is not eligible or the service has not been authorized, payment is not made to the provider and the claim is denied.

Missouri Medicaid Audit and Compliance validates a statistically valid sampling of claims payments to ensure that the services claimed by a waiver provider have been delivered.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (*select one*):**

- ☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☒ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ☐ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ☐ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ☒ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ☐ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ☐ The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ☒ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ☐ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)**g. Additional Payment Arrangements**

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ☒ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ☐ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ☒ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ☐ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

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

- ☒ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ☐ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of**

the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ☐ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- ☐ **Appropriation of State Tax Revenues to the State Medicaid agency**
☒ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The home and community based appropriations belong to the DHSS. Claims are processed through the MMIS and adjudicated for payment. During the adjudication process, the Department of Social Services/Division of Finance and Administrative Services has been granted authority by DHSS, to issue warrants to draw down funds from the DHSS state appropriation. Providers are then paid directly by the MO HealthNet Division, twice a month.

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- ☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

- ☐ **Applicable**

Check each that applies:

- ☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

☐ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

- a. Services Furnished in Residential Settings.** *Select one:*

☒ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

☐ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings: Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ☒ No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- ☐ Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ☒ No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- ☐ Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ Nominal deductible
- ☐ Coinsurance
- ☐ Co-Payment
- ☐ Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- ☒ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ☐ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: 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)

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	129655.91	16903.85	146559.76	259133.02	12320.48	271453.50	124893.74
2	137066.04	15827.57	152893.61	267554.84	15979.67	283534.51	130640.90
3	148310.57	14819.83	163130.40	276252.38	20725.63	296978.01	133847.61
4	156752.81	13876.24	170629.05	285228.51	26881.14	312109.65	141480.60
5	165744.79	12992.74	178737.53	294498.44	34864.84	329363.28	150625.75

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	210		210
Year 2	235		235
Year 3	260		260
Year 4	285		285
Year 5	310		310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay is determined based on the number of new participants entering and participants exiting the waiver at different times during the waiver year as follows:

Waiver Year 1 - 339 days
 Waiver Year 2 - 339 days
 Waiver Year 3 - 339 days
 Waiver Year 4 - 339 days
 Waiver Year 5 - 339 days

This waiver serves individuals who have been receiving or were eligible to receive private duty nursing services as a child under EPSDT in Missouri. DHSS has accurate data of the number of participants who may be entering the waiver each of the waiver years 1-5. Due to the participants' medically fragile conditions it is difficult to determine if these participants will survive until they are enrolled in this waiver and then how long they will remain on the waiver. Average Length of Stay as reported in the 372 Reports for FY 11, FY 12, FY13 and DHSS Data for FY14 & FY 15 were used to make these projections. There was not a consistent increase in the length of stay. The average length of stay was 339 days.

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 is projected based on the waiver services prior authorized through the end of State Fiscal Year 2015.

PDN authorization increased 2.25% annually since the last waiver projections. Projections reflect a 2.25% annual increase in authorized PDN. There was an increase in provider rates was appropriated by the Missouri General Assembly for Private Duty Nursing (PDN) in Fiscal Year 2014 and an increase of 3% for PDN may occur during Fiscal Year 2016, dependent on available funding. The service rate is projected to increase by 3% annually for waiver years 1-5.

Waiver Attendant Care services are authorized when state plan personal care is maximized or for personal care provided to accompany the participant in community activities. Projections reflect a 1.2% increase in authorized units per year. There was a 3% increase in provider rates appropriated by the Missouri General Assembly for Waiver Attendant Care in Fiscal Year 2014. These projections reflect 3% annual increase in the rate per unit.

Waiver supplies indicated a 12% increase in authorized expenses. The projections reflect a 12% increase annually for waiver supplies.

- 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 projected using actual data from State Fiscal Year 2013 and 2014 for state plan services for waiver participants. There has been a decrease of 6.8% in state plan services annually. The projections factor in the 6.8% decrease annually. Medicare Part D is no longer a factor in our determination of Factor D'.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on the actual average annual expenditures for MO HealthNet participants receiving services to meet their complex medical needs in an ICF/IID 2014. Expenditures have been increasing by 3.25% annually. The figures for Factor G reflect a 3.25% increase annually throughout the waiver period.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on the average state plan services for participants in an ICF-IID during the State Fiscal Years 2013 and 2014. There has been an increase of 29.7% in state plan services annually for ICF-IID participant. The projections factor in the 29.7% increase annually. Medicare Part D is no longer a factor in our determination of Factor G'.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Waiver Attendant Care	
Private Duty Nursing	
Specialized Medical Supplies	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Attendant Care Total:						443777.76
Waiver Attendant Care	1/4 hour	24	3901.00	4.74	443777.76	
Private Duty Nursing Total:						26371033.88
Private Duty Nursing	1/4 hour	209	15992.04	7.89	26371033.88	
Specialized Medical Supplies Total:						412929.00
Specialized Medical Supplies	Item	165	12.00	208.55	412929.00	
GRAND TOTAL:						27227740.64
Total Estimated Unduplicated Participants:						210
Factor D (Divide total by number of participants):						129655.91
Average Length of Stay on the Waiver:						339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Attendant Care Total:						500995.83
Waiver Attendant Care	1/4 hour	26	3948.58	4.88	500995.83	
Private Duty Nursing Total:						31182566.22
Private Duty Nursing	1/4 hour	234	16391.00	8.13	31182566.22	
Specialized Medical Supplies Total:						526956.48
Specialized Medical Supplies	Item	188	12.00	233.58	526956.48	
GRAND TOTAL:						32210518.53
Total Estimated Unduplicated Participants:						235
Factor D (Divide total by number of participants):						137066.04
Average Length of Stay on the Waiver:						339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Attendant Care Total:						561537.20
Waiver Attendant Care	1/4 hour	28	3995.00	5.02	561537.20	
Private Duty Nursing Total:						37333674.55
Private Duty Nursing	1/4 hour	259	17221.68	8.37	37333674.55	
Specialized Medical Supplies Total:						665535.84
Specialized Medical Supplies	Item	212	12.00	261.61	665535.84	
GRAND TOTAL:						38560747.59
Total Estimated Unduplicated Participants:						260
Factor D (Divide total by number of participants):						148310.57
Average Length of Stay on the Waiver:						339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Attendant Care Total:						627211.99
Waiver Attendant Care	1/4 hour	30	4043.92	5.17	627211.99	
Private Duty Nursing Total:						43214046.74
Private Duty Nursing	1/4 hour		17652.22	8.62	43214046.74	
GRAND TOTAL:						44674550.73
Total Estimated Unduplicated Participants:						285
Factor D (Divide total by number of participants):						156752.81
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		284				
Specialized Medical Supplies Total:						833292.00
Specialized Medical Supplies	Item	237	12.00	293.00	833292.00	
GRAND TOTAL:						44674550.73
Total Estimated Unduplicated Participants:						285
Factor D (Divide total by number of participants):						156752.81
Average Length of Stay on the Waiver:						339

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Attendant Care Total:						698008.27
Waiver Attendant Care	1/4 hour	32	4092.45	5.33	698008.27	
Private Duty Nursing Total:						49647171.40
Private Duty Nursing	1/4 hour	309	18093.52	8.88	49647171.40	
Specialized Medical Supplies Total:						1035704.52
Specialized Medical Supplies	Item	263	12.00	328.17	1035704.52	
GRAND TOTAL:						51380884.19
Total Estimated Unduplicated Participants:						310
Factor D (Divide total by number of participants):						165744.79
Average Length of Stay on the Waiver:						339