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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

DRAFT

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*):

Brain Injury Waiver

C. Type of Request: new

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**

☐ **New to replace waiver**
Replacing Waiver Number:

Base Waiver Number:

Amendment Number
(if applicable):

Effective Date: (mm/dd/yy)

Waiver Number:MO.1406.R00.00
Draft ID: MO.039.00.00

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

Regular Waiver

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

10/01/19

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

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

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

DRAFT

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

The Brain Injury Waiver (BIW) will provide home and community based services to participants with traumatic brain injuries ages 21 to 65.

Goals are to: 1) Provide cost-effective home and community based services for participants as an alternative to nursing home placement and 2) Assure that necessary safeguards have been taken to protect the health and welfare of participants receiving services under the BIW.

Objectives include: 1) Provide individual choice between nursing home 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, 3) Ensure the adequacy of medical care and waiver services, 4) Monitor each participants condition and continued appropriateness of participation through bi-annual home visits by authorized staff, and 5) Monitor provider provision of service through care plan reviews and documentation that identifies the participant's progress, the implementation of services, and the appropriateness of the services provided.

The waiver is administered by the Department of Health and Senior Services, Division of Community of Public Health (DHSS, DCPH) through an interagency agreement with the Single State Medicaid Agency, Department of Social Services, MO HealthNet Division (DSS, MHD). DHSS, DCPH, Bureau of Special Health Care Needs (SHCN) provides service coordination services for participants served by the waiver.

Waiver services are accessed through referral to the BIW for those participants ages 21 to 65 that meet the criteria for the waiver and desire to remain and/or return to their homes. Referrals are also accepted from health care providers, families, other state agencies, and other sources. BIW staff completes assessments for waiver eligibility.

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

- ◉ **No**
- ○ **Yes**

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

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

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

DRAFT

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.

DRAFT

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

DRAFT

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:

The state solicited input from stakeholders and providers during this new waiver development process. There were several meetings held to discuss the need for the waiver and the services provided in the waiver.

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

First Name: Glenda

Title: Assistant Deputy Director

Agency: Missouri Department of Social Services, MO HealthNet Division

Address: 615 Howerton Court

Address 2: P.O. Box 6500

City: Jefferson City

State: **Missouri**

DRAFT

Zip: 65102-6500

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

Fax: (573) 526-4651

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

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

Last Name: Jennifer

First Name: Braun

Title: Brain Injury Manager

Agency: Department of Health and Senior Services

Address: 920 Wildwood

Address 2: PO Box 570

City: Jefferson City

State: **Missouri**

Zip: 65102-0570

Phone: (573) 751-6246 **Ext:** ☐ **TTY**

Fax: (573) 751-6237

E-mail: jennifer.braun@health.mo.gov

DRAFT

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: Richardson

First Name: Todd

Title: Director

Agency: Department of Social Services, MO HealthNet Division

Address: 615 Howerton Court

Address 2: P.O. Box 6500

City: Jefferson City

State: **Missouri**

Zip: 65101

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

Fax: (573) 751-6564

E-mail: Marissa.Crump@dss.mo.gov

Attachments

Attachment #1: Transition Plan

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

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

DRAFT

☐ **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.

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 Medicaid 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.

DRAFT

(Complete item A-2-a).

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

Specify the division/unit name:

Missouri Department of Health and Senior Services, Division of Community and Public Health, Bureau of Special Health Care Needs

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:

DRAFT

The HCBS waiver quality management strategy specified throughout the waiver is used to ensure that the operating agency, the Department of Health and Senior Services (DHSS), Division of Community and Public Health (DCPH) is performing the delegated waiver operational and administrative functions in accordance with the waiver requirements during the period that the waiver is in effect. MHD and DCPH meet quarterly to discuss administrative/operational components of the waiver. This time is also used to discuss the quality assurances strategy specified throughout the waiver application. A Memorandum of Understanding (MOU) exists between the two agencies and communication remains open and additional discussions occur on an ongoing and as needed basis.

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

Appendix A: Waiver Administration and Operation

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

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

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

DRAFT

Appendix A: Waiver Administration and Operation

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

- ◉ **Not applicable**
- ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
  Check each that applies:
  - ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

  - ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	☐	☒
Waiver enrollment managed against approved limits	☒	☒
Waiver expenditures managed against approved levels	☒	☒
Level of care evaluation	☐	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒

DRAFT

Function	Medicaid Agency	Other State Operating Agency
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☒
Rules, policies, procedures and information development governing the waiver program	☒	☒
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participants assigned a waiver slot, not to exceed the maximum enrollment limit of the number of participants approved to be served in the waiver. Numerator = Number of participants assigned a waiver slot. Denominator = Number of the maximum enrollment limit of approved waiver slots.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS/Report from Operating Agency

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

DRAFT

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

DRAFT

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of manuals and directives reviewed by MHD applicable to the waiver. Numerator = Number of manuals and directives reviewed by MHD applicable to the waiver. Denominator = Total number of manuals and directives released by the operating agency applicable to the waiver.

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

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

DRAFT

Data Aggregation and Analysis:

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

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

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

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

DRAFT

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

Data Aggregation and Analysis:

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

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

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

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

DRAFT

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

DRAFT

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Issues which require individual remediation may come to MHD's attention through review of annual reports as well as through day-to-day activities and communications. Activities may include utilization review and quality review processes or complaints from MHD participants by phone or letter relating to waiver participation/operation. MHD addresses individual problems related to delegated functions as they are discovered by contacting SHCN and advising them of the issue. A follow-up memo or e-mail is sent from MHD to SHCN identifying the problem and, if appropriate, a corrective action resolution. While some issues may need to be addressed immediately, SHCN is required to provide a written response to MHD that specifically addresses the problem identified by MHD. Based upon the situation, MHD will establish an appropriate timeframe for SHCN to respond. Written documentation is maintained by both MHD and SHCN and, as needed, discussions will be included during quarterly meetings. Any trends or patterns will be discussed and resolved as appropriate. Individual problems that are part of the report process will be included in the appropriate reports.

ii. Remediation Data Aggregation

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

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

DRAFT

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☒	**Brain Injury**	21	65	☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

DRAFT

Individuals must have a documented traumatic brain injury resulting in functional limitations which have been clinically documented by a neuropsychologist or physician. The injury must be one that temporarily or permanently impairs the individual's behavioral, cognitive, or physical functions.

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:

Participants with a physically disability reaching the age of 65 remain eligible and can transition to services through the Aged and Disabled Waiver as a result of the "Aged" category. No later than three months prior to the individual's 65th birthday, the needs of the participant and how to best meet their needs will be reassessed. BIW staff will assist the participant with obtaining an evaluation for eligibility and assist with the transition of services through coordination and communication with DHSS/Division of Senior and Disability Services (DSDS).

Alternative services such as State Plan Personal Care and available community supports such as the Brain Injury Association of Missouri (BIA-MO) and additional community support services will be accessed if necessary.

Individuals that meet the eligibility requirements of the Adult Brain Injury (ABI) Program have the option of receiving services while dually enrolled in the BIW and after waiver services end.

DHSS/SHCN administers the Adult Brain Injury (ABI) Program which is funded by general revenue and the Brain Injury Fund.

Individuals may receive services through the ABI Program and receive service coordination regardless of income. Participants who are enrolled in the BIW may also receive services through the ABI Program.

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.

(a) Individuals participating in this waiver live alone, with family members/caregiver, or have funding from other public programs that in combination with waiver services ensures the individuals have sufficient services and supports to assure their health and safety. Individuals are assessed prior to entering this waiver and annually thereafter to identify their needs and estimate the cost of waiver services necessary to meet the needs.

(b) Services will be capped at $27,500 per participant annually. Any service array can be authorized up to the maximum of this total cap with the exception of Assistive Technology and Environmental/Home Modifications.

(c) Assistive Technology and Environmental/Home Modifications are each capped at $5,000 annually. This is included in the total of the annual $27,500 cap per participant annually.

The State reviewed Brain Injury Waivers in other states and their cost limits for similar services and similar waiver slots to establish the rational and identify the individual cost limits. The State also reviewed the cost of nursing home level of care to ensure the State remained cost effective.

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

◉ **The following dollar amount:**

Specify dollar amount: 27500

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:

DRAFT

Appendix B: Participant Access and Eligibility

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

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

In advance of enrollment in the waiver, the needs of the individual and how best to meet the needs are identified. From this assessment, a plan of care is developed that specifies the amount, frequency, and duration of all services that are needed to assure health and safety. All potential sources for meeting the needs will be explored such as private insurance, other federal programs, State Plan Medicaid, other state and local programs, as well as, support provided by family.

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

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

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

☒ **Other safeguard(s)**

Specify:

BIW staff will inform the participant of other options and make referrals to other available services within the community. Other alternatives may also include the consideration of new or additional State Plan services including, but not limited to, Personal Care services, and provide the participant with information regarding other waiver services.

If it is determined that the individual's health and welfare cannot be assured in the community by any or a combination of the above actions, the State may find it necessary to discharge the person from the waiver and may recommend institutional services.

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:

DRAFT

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	20
Year 2	20
Year 3	20

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	

DRAFT

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Individuals are enrolled based upon the individual meeting the nursing home level of care and criteria specified in this waiver. In the event all slots are filled during a waiver year, individuals will be enrolled based upon the score of the level of care determination. If individuals have the same score, the date of referral will be used. The level of care determination is a standardized process that assigns points with the higher points representing individuals who have the greatest need in the State. BIW staff will complete this determination.

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)**

DRAFT

○ **% 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:

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

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

◉ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

○ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

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

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

DRAFT

☐ **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.

DRAFT

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

DRAFT

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

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:

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

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

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

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

DRAFT

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.

DRAFT

In order to be eligible for enrollment in the BIW, individuals must meet nursing facility level of care as specified in state regulation at 19 CSR 30-81.030.

Points are assigned based on the degree of human assistance needed by the individual (or the frequency of physician's ordered care) in 9 categories that explore areas of daily living. The categories are: (1) Monitoring: the amount of medical oversight needed to remain independent. (2) Medications: the ability to administer medicine and difficulty of drug regime. (3) Treatments: physician ordered medical procedure(s) intended to treat a specific medical condition. (4) Restorative: teaching and/or training activities designed to maintain or restore a person to a higher level of functioning. (5) Rehabilitative: physician ordered rehabilitation therapy (speech, occupational, physical) - points are based on frequency of services. (6) Personal Care: bowel or bladder problems or the ability to bathe, shampoo, etc. (7) Dietary: the degree of specialized diet or the ability to prepare and eat meals. (8) Mobility: the ability to move from place to place. (9) Behavior: any problems associated with orientation, memory recall, and judgment.

Scoring Methodology: any combination of points which meets the level of care specified in 19 CSR 30-81.30 and 3 rehabilitation and 3 functional needs qualifies an individual to receive BIW services. Points are assigned in each of the 9 categories in 3 point increments: 0 points: assigned if the individual requires no assistance, is independent, does not have the treatment/therapy/problem, etc. 3 points: assigned if problems are identified: personal oversight or management is required; minimum numbers of treatments/therapies/medications are ordered. 6 points: assigned if problems are moderate; daily or regular human assistance is required; moderate frequency of treatments/therapies ordered by a physician. 9 points: assigned when maximum physical/medical problems require total human assistance.

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 ADLs.
6 points Client requires daily assistance with ADLs and/or is incontinent of bladder and bowel 50% of the time.
9 points Client requires total assistance with ADLs.

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 nursing facility level of care and have a need for at least 3 of the following rehabilitation criteria and 3 functional limitations:

Rehabilitation Criteria in 3 or more of the following:
1. Assistive Devices
2. Environmental/Home Modifications
3. Physical Therapy
4. Speech Therapy
5. Occupational Therapy
6. Behavior Analysis
7. Personal Care services (above State Plan)
8. Cognitive Rehabilitation Therapy

Functional Criteria in 3 or more of the following:
1. Self-Care
2. Communication
3. Memory
4. Learning
5. Mobility
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 nursing facility in that the same criteria are assessed; however, point descriptions are more appropriate to the assessment of adults with traumatic brain injury.

The difference (other than lay-out/format) between the level of care determination tools utilized for determining eligibility for nursing facility admission and waiver services is that additional information is obtained to assist in service plan development. Both tools use the same scoring methodology described in Appendix B-6-d. The 9 categories and scoring methodology are established in the state nursing home regulation. As both tools utilize the same categories and scoring methodology based on the same state regulation, the outcomes from the DHSS/SHCN level of care instruments are reliable, valid, and fully comparable to the nursing facility level of care instrument.

A participant assessment is completed to screen participants based upon the 9 level of care categories outlined in B-6-D. A participant rehabilitation assessment will be completed that measures the participant's need for assistive devices; environmental/home modifications; behavioral, cognitive, occupational, physical, and speech therapies; ability to communicate; auditory; visual; behavioral; memory; pain; skin condition; sleep; substance use; environment; and social supports. The participant must show a need in 3 of the rehabilitation areas (Personal Care services (above State Plan), assistive technology, environmental access and modification, cognitive therapy, occupational therapy, physical therapy, or speech therapy to meet the rehabilitation criteria to qualify for BIW services.

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:

BIW staff attends a bi-annual home visit with each waiver participant to evaluate current needs. The Level of Care Determination (LOC) form is completed every 6 months. A comprehensive assessment is completed annually to determine client choice, service plan/care needs, health and safety risks, and medical necessity. The same process is used for initial evaluation and re-evaluation.

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):*

DRAFT

The Brain Injury Manager maintains an electronic tracking system to assure that each participant is assessed every 6 months. A report is produced monthly by the SHCN 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 office in which the BIW staff who completes the assessments is domiciled. The files are stored in locked file cabinets for as long as the participant is receiving waiver services. Upon discharge of the participant the record is archived and maintained indefinitely.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of level of care determinations completed for new enrollees prior to receipt of waiver services. Numerator = Number of level of care determinations completed for new enrollees prior to receipt of waiver services. Denominator = Total number of new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review by the Brain Injury Manager and 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):*

DRAFT

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

DRAFT

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

Performance Measure:
Number and percent of level of care determinations completed for ALL applicants indicating a need for NH LOC. Numerator = Number of LOC determinations completed for ALL applicants indicating a need for NH LOC. Denominator = Total number of applicants indicating a need for NH LOC.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review by the Brain Injury Manager and MMIS

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

DRAFT

	Specify:	

Data Aggregation and Analysis:

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

DRAFT

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

Performance Measures

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

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of initial Level of care determinations (LOC)completed by qualified staff. Numerator = Number of initial LOC determinations completed by qualified staff. Denominator = Total number of completed initial LOC determinations reviewed.

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

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

DRAFT

Data Aggregation and Analysis:

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

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

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

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

DRAFT

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

DRAFT

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

The Brain Injury Manager reviews all LOCs to assure that eligibility criteria is met for initial enrollment and subsequent re-evaluations. The Brain Injury Manager and/or designee contacts BIW staff with findings via 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 the corrective action was received by the Brain Injury Manager. A copy of the correction is required for the participant record. The Brain Injury Manager tracks and trends this data and identifies if system changes are needed to maintain compliance with the waiver. The Brain Injury Manager communicates system changes to SHCN staff as needed, 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

i. informed of any feasible alternatives under the waiver; and

DRAFT

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 BIW staff with the participant and/or responsible party annually. The participant and/or responsible party is required to sign the form. The participant and/or responsible party can then make an informed choice between receiving institutional or home and community based services and choice of provider. 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 office where BIW staff is domiciled. The files are stored in locked file cabinets for as long as the participant is receiving waiver services. Upon discharge of the participant, the record is archived and maintained indefinitely.

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):

DRAFT

It is the policy of the 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 DHSS 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 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 participants, 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 LEP. Contact should be recorded by the employee and the LEP Data Form can be used for convenience in recording said contact.
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 population.
5. DHSS will strive to provide visual and audio information in the appropriate language to participants with LEP. 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 official 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 BIW

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. Participants of DHSS:
1. No participant, applicant or their representative will be required to provide or pay for the services of a translator or interpreter.
2. For participants with LEP, DHSS employees will identify and document on the participant's record the primary language/dialect of the participant 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 participant and the use of such a person would not compromise the effectiveness of services or violate the participant's confidentiality, and the participant 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	**Personal Care Services**		
Other Service	**Applied Behavior Analysis**		
Other Service	**Assistive Technology**		
Other Service	**Cognitive Rehabilitation Therapy**		
Other Service	**Environmental Access and Modification**		
Other Service	**Neuropsychological Evaluation**		
Other Service	**Occupational Therapy**		
Other Service	**Physical Therapy**		
Other Service	**Speech Therapy**		

DRAFT

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Personal Care Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care

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

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

Service Definition *(Scope):*

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

Personal Care services that are provided when Personal Care services furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not differ from Personal Care services furnished under the State Plan. Additional Personal Care Services provided under the waiver are not limited in amount or frequency. Provider qualifications specified in the State Plan apply.

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

Personal Care services 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. Personal Care services may be utilized for the care in the home and outside the home in the performance of normal life activities by BIW participants. The scope and nature of these services do not differ from State Plan Personal Care services with the exception that Personal Care paid by the waiver may be provided outside the home. The provider qualifications specified under the State Plan apply. This service may not include skilled or nursing care.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Personal Care Provider

Provider Qualifications

License *(specify):*

DRAFT

There are no licensing requirements.

Certificate *(specify):*

There are no certification requirements.

Other Standard *(specify):*

Personal Care Worker must meet the following qualifications:
1. Be at least 18 years of age;
2. Be able to read, write, and follow directions; and
3. Have at least 6 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 training; and
4. May not be a family member of the recipient for whom Personal Care is to be provided. A family member is defined as a parent; sibling; child by blood, adoption or marriage; spouse; grandparent, or grandchild.

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

Personal Care worker must have 20 hours of orientation, including two hours orientation by the provider agency and the agencies protocols for handling emergencies, within 30 days of employment.
Eight hours of classroom training completed prior to client contact, 12 hours of orientation may be waived with adequate documentation in the employee's records that the aid received similar training during the current or preceding state fiscal year or has been employed as an aide at an in-home or home health agency at least half time for six months or more within the current or preceding state fiscal year, a certified nurse's assistant, licensed practical nurse, or registered nurse. An additional 10 hours of in-service training is required annually. Six of the ten hours should be classroom instruction and four hours may be via an appropriate training method. The provider must keep documentation of the training hours.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency enrolled with Missouri Medicaid Audit and Compliance (MMAC) as a MO HealthNet provider.

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

Personal Care providers are generally audited every three years by MMAC, but it can vary depending on whether a complaint or allegation of fraud or other program violations are received, which may trigger an audit before the next three year audit is due. Training records of managers and employees are reviewed for compliance during the audits.

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:

Applied Behavior Analysis

HCBS Taxonomy:

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

Service Definition *(Scope):*

DRAFT

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

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

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

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

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

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

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

Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.

Observational Follow-up Assessment: Behavioral follow-up assessment(s) may be required to enable the Qualified Health Care Professional (QHCP) to finalize or fine-tune the baseline results and plan of care that were initiated in the identification assessment. This service is performed by a technician under the direction of a QHCP or licensed assistant behavior analyst. The QHCP or licensed assistant behavior analyst may or may not be on-site during the face-to-face assessment process. Observational follow-up is provided to individuals who present with specific destructive behavior(s)(e.g., self-injurious behavior, aggression, property destruction) or behaviors or deficits in communication or social relatedness. Observational follow-up includes the use of structured observation and/or standardized and non-standardized tests to determine levels of adaptive behavior. Areas assessed may include cooperation, motivation, visual understanding, receptive and expressive language, imitation, requests, labeling, and leisure and social interactions. Specific destructive behavior(s)assessments include structured observational testing to examine events, cues, responses, and consequences associated with the behavior(s).

Exposure Follow-up Assessment: Is administered by the QHCP with the assistance of one or more technicians. The follow-up assessment includes the QHCP's interpretation of results, discussion of findings, and recommendations with primary caregiver(s), and preparation of report. Typical individuals for these services include those with more specific severe destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction). Specific severe destructive behavior(s) are assessed using structured testing to examine events, cues, responses, and consequences associated with the behavior. Exposure behavioral follow up assessment includes exposing the individual to a series

of social and environmental conditions associated with the destructive behavior(s). Assessment methods include using testing methods designed to examine triggers, events, cues, responses, and consequences associated with the before mentioned maladaptive behavior(s). This assessment is completed in a structured, safe environment.

Adaptive Behavior Treatment: addresses the individual's specific target problems and treatment goals as defined in previous assessments. Adaptive behavior treatment is based on principles including analysis and alteration of contextual events and motivating factors, stimulus-consequence strategies and replacement behavior, and monitoring of outcomes. Goals of adaptive behavior treatment may include reduction of repetitive and aberrant behavior, and improved communication and social functioning. Adaptive behavior skill tasks are often broken down into small, measurable units, and each skill is practiced repeatedly until the individual masters it. Adaptive behavior treatment may occur in multiple sites and social settings (e.g., controlled treatment programs with an individual alone or in a group setting, home, or other natural environment). All ABA services are considered short term services whose objectives are to provide changes in patterns of interactions, daily activities, and lifestyle including provider family/staff/caregivers skills to teach the individuals supported adaptive skills and skills to more appropriately address problem behaviors. The development of skills in the individual and in the family/staff/caregivers is a key component to these services. In addition, it is essential that the strategies developed are adapted to more typical types of support strategies so that the treatment plan, called the BSP, is replaced with these more typical strategies as the service is successful.

Adaptive behavior treatment is further composed of the following elements:

Adaptive Behavior Treatment by Protocol by Technician: is administered by a single technician or licensed assistant behavior analyst under the direction (on-site or off-site) of the QHCP by adhering to the protocols that have been designed by the QHCP. This service is delivered to the individual alone or while attending a group session.

Adaptive behavior treatment by protocol by technician includes skill training delivered to an individual who, for example, has poor emotional responses (eg, rage with foul language and screaming) to deviation in rigid routines. The technician introduces small, incremental changes to the individual's expected routine along one or more stimulus dimension(s) and a reinforcement is delivered each time the individual appropriately tolerates a given stimulus change until the individual tolerates typical variations in daily activities without poor emotional response.

The QHCP directs the treatment by designing the overall sequence of stimulus and response fading procedures, analyzing the technician-recorded progress data to assist the technician in adhering to the protocol, and judging whether the use of the protocol is producing adequate progress.

Adaptive Behavior Treatment by Protocol Modification: Unlike the adaptive behavior treatment by protocol by technician, adaptive behavior treatment by protocol modification is administered by a QHCP or licensed assistant behavior analyst who is face-to-face with a single individual. The service may include demonstration of the new or modified protocol to a technician, guardian(s), and/or caregiver. A modified treatment protocol is administered by the QHCP to demonstrate to the new caregiver how to apply the protocol(s) to facilitate the desired behavior.

Exposure Adaptive Behavior Treatment with Protocol Modification: describes services provided to individuals with one or more specific severe destructive behaviors (eg, self-injurious behavior, aggression, property destruction), with direct supervision by a QHCP which requires two or more technicians face-to-face with the individual for safe treatment. Technicians elicit behavioral effects of exposing the individual to specific environmental conditions and treatments. Technicians record all occurrences of targeted behaviors. The QHCP previews and analyzes data and refines the therapy using single-case designs; ineffective components are modified or replaced until discharge goals are achieved (eg, reducing destructive behaviors by at least 90%, generalizing the treatment effects across caregivers and settings, or maintaining the treatment effects over time). The treatment is conducted in a structured, safe environment. Precautions may include environmental modifications and/or protective equipment for the safety of the individual or the technicians. Often these services are provided in intensive out-patient, day treatment, or inpatient facilities, depending on the dangerousness of the behavior.

Family Treatment Guidance: Family/guardian/caregiver adaptive behavior treatment guidance is administered by a QHCP or licensed assistant behavior analyst face-to-face with family/guardian(s)/caregiver(s) and involves teaching family/guardian(s)/caregiver(s) to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits.

Treatment Social Skills Group: Adaptive behavior treatment social skills group is administered by a QHCP or licensed assistant behavior analyst face-to-face with multiple individuals, focusing on social skills training and identifying and targeting individual patient social deficits and problem behaviors. The QHCP or licensed assistant behavior analyst monitors the needs of individuals and adjusts the therapeutic techniques during the group, as needed. Services to increase target social skills may include modeling, rehearsing, corrective feedback, and homework assignments. In contrast to adaptive behavior treatment by protocol techniques, adjustments are made in real time rather than for a subsequent services.

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

Behavior Identification Assessment: A unit is 15 minutes. Limited to eight units per year.

Behavior Identification Supporting Assessment: A unit is 15 minutes. Limited to 32 units per day, 100 units per year.

Behavior Identification Supporting Assessment can be done by the Registered Behavior Technician (RBT) under the direction of the QHCP that is a Licensed Behavior Analyst (LBA), or under the direction of a LaBA; the service can be done by the QHCP or LaBA.

Observational Behavioral Follow-Up Assessment: A unit is 15 minutes. Limited to 10 units per day, 50 units per week, and 50 units per year.

All Observational Behavior Follow-Up Assessments must be administered by the RBT under the direction of the QHCP that is a LBA, or under the direction of a LaBA; the service can also be done by the QHCP or LaBA.

Adaptive Behavior Treatment by Protocol by Technician: A unit is 15 minutes. Limited to 32 units per day, 160 units per week, and 600 units per month.

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

Adaptive Behavior Treatment with Protocol Modification: A units is 15 minutes. Limited to 32 units per day, 120 units per week, and 270 units per year.

Adaptive Behavior Treatment with Protocol Modification, extensions may be approved by the Brain Injury Manager, or degree. 10% of units authorized in a plan year for this service would be appropriately utilized for protocol modification and data analysis and that this would require documentation as with all other units in addition to the written modified protocol and graphic display with current data and progress report describing the analysis and effects on intervention strategies related to the analysis.

Exposure Adaptive Behavior Treatment with Protocol Modification: A units is 15 minutes. Limited to 34 units per day, 130 units per week, and 320 units per month.

Exposure Adaptive Behavior Treatment with Protocol Modification must receive prior approval by the Brain Injury Manager.

Family Adaptive Behavior Treatment Guidance, 15 minute unit: limited to four units per day, 20 units per week, and 40 units per month. In addition, no more than eight family members/guardians/caregivers can be present for a unit to be billed. This service can be concurrent to any of the other treatment services.

Adaptive Behavior Treatment Social Skills Group, 15 minute unit: limited to six units per day, 30 units per week, and 60 units per month. In addition, no more than eight individuals can be present for a unit to be billed. This service can be concurrent to any of the other treatment services.

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
Individual	Qualified Health Care Professional (QHCP)
Agency	Qualified Health Care Professional (QHCP)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Applied Behavior Analysis

Provider Category:

Individual

Provider Type:

Qualified Health Care Professional (QHCP)

Provider Qualifications

License *(specify):*

Provider must be a licensed Psychologist with education and experience in ABA, a licensed Behavior Analyst, or a licensed Assistant Behavior Analyst. Provisionally licensed providers are not eligible to enroll.

RSMo Section 337.315.1 provides the license and practice requirements of Applied Behavior Analysis. Graduate degree and Missouri State license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis. RSMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224 Or Missouri State license as an assistant Behavior Analyst RSMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224.

Certificate *(specify):*

Registration as Registered Behavior Technician with the Behavior Analyst Certification Board. 20 CSR 2063-3.005 is the state regulation that governs Behavior Analyst certification.

Other Standard *(specify):*

DHSS contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

DRAFT

SHCN will verify prior to contract approval and renewal every 3 years; as needed based on service monitoring concerns.
Required professional licenses and certifications are verified monthly by MMAC in accordance with 42 CFR 455.436.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Applied Behavior Analysis

Provider Category:

Agency

Provider Type:

Qualified Health Care Professional (QHCP)

Provider Qualifications

License *(specify):*

Agency employing a licensed Psychologist with education and experience in ABA, a licensed Behavior Analyst, or a licensed Assistant Behavior Analyst. Provisionally licensed providers are not eligible to enroll.

RSMo Section 337.315.1 provides the license and practice requirements of Applied Behavior Analysis. Graduate degree and Missouri State license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis. RSMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224 Or Missouri State license as an assistant Behavior Analyst RSMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224.

Certificate *(specify):*

Registration as Registered Behavior Technician with the Behavior Analyst Certification Board. 20 CSR 2063-3.005 is the state regulation that governs Behavior Analyst certification.

Other Standard *(specify):*

DHSS contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval and renewal every 3 years; as needed based on service monitoring concerns.
Required professional licenses and certifications are verified monthly by MMAC in accordance with 42 CFR 455.436.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

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

Service Definition *(Scope):*

DRAFT

This service includes Personal Emergency Response Systems (PERS), Medication Reminder Systems (MRS), and other electronic technology that protects the health and welfare of a participant. This service may also include electronic surveillance/monitoring systems using video, web-cameras, or other technology. Assistive technology shall not include household appliances or items that are intended for purely diversional or recreational purposes. Assistive technology should be evidenced based, and shall not be experimental.

Electronic surveillance/monitoring systems using video, web-cameras, or other technology is only available on an individual, case-by-case basis when an individual requests the service and the planning team agrees it is appropriate and meets the health and safety needs of the individual. Remote monitoring technology may only be used with full consent of the individual and their guardian. Remote monitoring will enable a person to be more independent and less reliant on staff to be physically present with them at all times, in particular for night time supports.

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

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

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

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

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

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

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

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

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

and must be portable.

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

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

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

Frequency: Prior to contract approval or renewal; service review every 2 years; as needed based on service monitoring concerns.

Training the waiver participant in the operation and maintenance of equipment will also be covered. Coverage shall also include the costs of maintenance and upkeep of equipment while the participant is enrolled in the waiver.

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

$5,000 annual cost limit per participant.

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

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

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

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

Provider Specifications:

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

DRAFT

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Electronic Communication Equipment and Monitoring Company

Provider Qualifications

License *(specify)*:

Certificate *(specify):*

Other Standard *(specify):*

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

Provider must have a contract with DHSS and be registered and in good standing with the Missouri Secretary of State.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval and renewal every 3 years; as needed based on service monitoring concerns.

DRAFT

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:

Cognitive Rehabilitation Therapy

HCBS Taxonomy:

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

10 Other Mental Health and Behavioral Services	10070 psychosocial rehabilitation

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

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

Service Definition *(Scope):*

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

Cognitive Rehabilitation Therapy includes goal oriented counseling to maximize strengths and reduce behavior problems and/or functional deficits, which interfere with an individual's personal, familial, and vocational or community adjustment. It can be provided to individuals and families when the participant is present with the family. This service is not available to adults when State Plan psychology services are appropriate to meet the individual's needs.

Cognitive Rehabilitation Therapy includes psychological testing, initial assessment, periodic outcome evaluation and coordination with family members, caretakers, and other professionals in addition to direct counseling. This service is needed by certain waiver participants whose living arrangement, job placement, or day activity is at risk due to maladaptive behavior or lack of adjustment.

Services can be provided in the home or outside of the participant's home in a professional clinic/office setting.

The planning team ensures this service does not duplicate, nor is duplicated by, any other services provided to the individual. Counseling is a cost effective alternative to placement in nursing home placement.

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

This service is not available adults when State Plan psychology services are appropriate to meet the individual's needs.

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
Individual	**Professional Counselor**
Agency	**Agency enrolled as a waiver provider employing psychologist, counselor, or social worker licensed in accordance with RSMo. Chapter 337**

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy

Provider Category:

Individual

Provider Type:

Professional Counselor

Provider Qualifications

License *(specify):*

Individual enrolled as a licensed psychologist, counselor, or social worker licensed in accordance with RSMo. Chapter 337

Certificate *(specify):*

Other Standard *(specify):*

DHSS Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval and renewal every 3 years; as needed based on service monitoring concerns.
Required professional licenses and certifications are verified monthly by MMAC in accordance with 42 CFR 455.436.

DRAFT

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy

Provider Category:

Agency

Provider Type:

Agency enrolled as a waiver provider employing psychologist, counselor, or social worker licensed in accordance with RSMo. Chapter 337

Provider Qualifications

License *(specify):*

Agency enrolled as a waiver provider employing psychologist, counselor, or social worker licensed in accordance with RSMo. Chapter 337.

Certificate *(specify):*

Other Standard *(specify):*

DHSS Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval and renewal every 3 years; as needed based on service monitoring concerns.
Required professional licenses and certifications are verified monthly by MMAC in accordance with 42 CFR 455.436.

DRAFT

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Access and Modification

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

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

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

$5,000 annual cost limit per participant.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Contractor
Agency	Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Access and Modification

Provider Category:

Individual

Provider Type:

Contractor

Provider Qualifications

License *(specify)*:

DRAFT

Certificate *(specify):*

Other Standard *(specify):*

Must have applicable business license and meet applicable building codes; DHSS Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval or renewal every 3 years; as needed based on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Access and Modification

Provider Category:

Agency

Provider Type:

Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must have applicable business license and meet applicable building codes; DHSS Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval or renewal every 3 years; as needed based on service monitoring concerns.

DRAFT

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:

Neuropsychological Evaluation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

DRAFT

Neuropsychological evaluation and consultation consists of the administration and interpretation of a standardized battery of neuropsychological tests to provide information about a participant's cognitive strengths and weaknesses following a traumatic brain injury (TBI). This service includes consultation with the participant, guardian, family, or other significant key person designated by the participant, and BIW staff for information gathering and/or interpretation of results.

Evaluation must be adapted to the cultural, ethnic, linguistic, and communication background of the participant and family.

Neuropsychological evaluation may be provided under the following circumstances:
* A neuropsychological evaluation has not been previously completed, and information is needed by the planning team to assist in identifying a feasible long-term goal, or
* Significant changes in participant's functional status have occurred and the information from a previous neuropsychological evaluation is not representative of present functioning, and information is needed by the planning team to assist in identifying a feasible long-term goal.

The following tests are approved as usual and customary:
Wechsler Adult Intelligence Scale (WAIS-IV)
Test of Premorbid Functioning (TOPF)
Trails A and B
Stroop
Symbol Digit Modality Test (SDMT)
Wechsler Memory Scale (WMS-IV)
California Verbal Learning Test (CVLT-2)
Category Test
Brief Visual Memory Test (BVMTR)
Judgment of Line Orientation (JOLO)
Rey Complex Figure (Copy)
Grooved Peg Board
Finger Agnosia
Grip Strengh
Boston Naming Test (BNT)
Controlled Oral Word Association Test (COWAT)
Animal Naming
Beck Depression Inventory (BDI-II)
Beck Anxiety Inventory (BAI-II)
Halstead-Reitan Battery
Luria-Nebraska Battery
NEPSY

The following abilities must be addressed in the evaluation report:
* Intelligence
* Academic functions
* Memory
* Attention
* Language
* Visual-Spatial skills
* Executive Functions
* Motor Skills
* Sensory Perception
* Emotional-behavioral functioning
* Speed of information processing

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

Neuropsychological evaluation may be provided under the following circumstances:
* A neuropsychological evaluation has not been previously completed, and information is needed by the planning team to assist in identifying a feasible long-term goal, or
* Significant changes in participant's functional status have occurred and the information from a previous neuropsychological evaluation is not representative of present functioning, and information is needed by the planning team to assist in identifying a feasible long-term goal.

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
Individual	Psychologist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Neuropsychological Evaluation

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Provider must be a licensed Psychologist with experience in TBI. Provisionally licensed providers are not eligible to enroll.

RSMo 337.010.1 defines psychologist and 20 CSR 2235-1.015 provides rule on neuropsychological testing.

Certificate *(specify):*

There are no applicable certifications.

Other Standard *(specify):*

Must have a specialty in neuropsychology. The individual service provider must be a MO HealthNet enrolled provider to provide the service. The provider contract will require at least one year of experience working with people with TBI.

DHSS Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

DRAFT

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval and renewal every 3 years as needed based on service monitoring concerns.
Required professional licenses and certifications are verified monthly by MMAC in accordance with 42 CFR 455.436.

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:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Occupational therapy requires prescription by a physician and evaluation by a certified Occupational Therapist (OT) or certified Occupational Therapeutic Assistant (COTA) under the supervision of an OT. The service includes evaluation, plan development, direct therapy, consultation and training of caretakers and others who work with the individual. It may also include therapeutic activities carried out by others under the direction of an OT or COTA. Examples are using adaptive equipment, proper positioning, and therapeutic exercises in a variety of settings. Services can be provided in the home or outside of the participant's home in a professional clinic/office setting.

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

Services must be required in the plan of care and prescribed by a physician.

DRAFT

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
Individual	Occupational Therapist
Agency	Agency employing licensed OT and may also employ registered COTAs supervised by licensed OT.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Licensed as an OT per RSMo. 324.050-324.089 and CSR 2205-3.010 - CSR 2205.3.070

Certificate *(specify):*

Certified per RSMo 334.735 334.746 as OT by AOTA or registered as a COTA

Other Standard *(specify):*

DHSS Contract; OT must be either certified as an OT by the American Occupational Therapy Association or registered as a COTA. Requirements for registration as a COTA in Missouri are: Attainment of a two-year associate degree from an accredited college; successful completion of a state exam; and registration with the State Division of Professional Registration. In addition, COTAs must receive supervision from a professional OT on a periodic, routine, and regular basis.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval and renewal every 3 years; as needed based on service monitoring concerns.
Required professional licenses and certifications are verified monthly by MMAC in accordance with 42 CFR 455.436.

DRAFT

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Agency employing licensed OT and may also employ registered COTAs supervised by licensed OT.

Provider Qualifications

License *(specify):*

Licensed as an OT per RSMo. 324.050-324.089 and CSR 2205-3.010 - CSR 2205.3.070

Certificate *(specify):*

Certified per RSMo 334.735 334.746 as OT by AOTA or registered as a COTA.

Other Standard *(specify):*

DHSS Contract; Occupational therapist must be either certified as an OT by the American Occupational Therapy Association or registered as a COTA. Requirements for registration as a COTA in Missouri are: Attainment of a two-year associate degree from an accredited college; successful completion of a state exam; and registration with the State Division of Professional Registration. In addition, COTAs must receive supervision from a professional OT on a periodic, routine, and regular basis.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval and renewal every 3 years; as needed based on service monitoring concerns.
Required professional licenses and certifications are verified monthly by MMAC in accordance with 42 CFR 455.436.

DRAFT

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:

Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Physical Therapy treats physical motor dysfunction through various modalities as prescribed by a physician and following a physical motor evaluation. It is provided to individuals who demonstrate developmental, habilitative, or rehabilitative needs in acquiring skills for adaptive functioning at the highest possible level of independence.

Physical Therapy requires a prescription by a physician and evaluation by a certified physical therapist (PT). The service includes evaluation, plan development, direct therapy, consultations and training of caretakers and others who work with the individual. A certified physical therapeutic assistant (CPTA) may provide direct therapy services under the supervision of a PT.

This service may include clinical consultation provided to individuals, parents, primary caregivers, and other programs or habilitation services providers.

A unit of service is 1/4 hour.

Therapies available to adults in under the state plan are for rehabilitation needs only. Therapies in the waiver are above and beyond what the state plan provides. Therapies in the waiver are more habilitative in nature; habilitative therapy is not available under the state plan.

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

Services must be required in the plan of care and prescribed by a physician.

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	Physical Therapist
Individual	Physical Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Licensed per RSMo. 334.530-334.625

Certificate *(specify):*

RSMo 20 CSR 2150-3.010-20 CSR 2150-3.110

Other Standard *(specify):*

DHSS Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval and renewal every 3 years; as needed based on service monitoring concerns.
Required professional licenses and certifications are verified monthly by MMAC in accordance with 42 CFR 455.436.

DRAFT

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Licensed per RSMo. 334.530-334.625

Certificate *(specify):*

RSMo 20 CSR 2150-3.010-20 CSR 2150-3.110

Other Standard *(specify):*

DHSS Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval and renewal every 3 years; as needed based on service monitoring concerns.
Required professional licenses and certifications are verified monthly by MMAC in accordance with 42 CFR 455.436.

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:

Speech Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

DRAFT

Speech therapy is for individuals who have speech, language, or hearing impairments. Services may be provided by a licensed speech language therapist. The individual's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified Speech Therapist. The need for services must be identified in the plan of care and prescribed by a physician. Speech therapy provides treatment for delayed speech, stuttering, spastic speech, aphasic disorders, and hearing disabilities requiring specialized auditory training, lip reading, signing, or use of a hearing aid. Services can be provided in the home or outside of the participant's home in a professional clinic/office setting.

Services may include consultation provided to families, other caretakers, and habilitation service providers. A unit of service is 1/4 hour.

Waiver providers must be licensed by the State of Missouri as a Speech Therapist. The Medicaid Waiver enrolled provider may employ a person who holds a provisional license from the State of Missouri to practice speech-language pathology or audiology. Persons in their clinical fellowship may be issued a provisional license. Clinical fellowship is defined as the supervised professional employment period following completion of the academic and practicum requirements of an accredited training program. Provisional licenses are issued for one year. Within 12 months of issuance, the applicant must pass an exam promulgated or approved by the board and must complete the masters or doctoral degree from an institution accredited by the Council on Academic Accreditation of the American Speech-Language-Hearing Association in the area in which licensing is sought. Provisionally licensed speech therapists must receive periodic, routine supervision from their employer, a Medicaid waiver enrolled speech therapy provider.

Therapies available to adults under the state plan are for rehabilitation needs only. Therapies in the waiver are above and beyond what the state plan provides. Therapies in the waiver are more habilitative in nature; habilitative therapy is not available under the state plan.

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

The participant's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified Speech Therapist. Services must be required in the plan of care and prescribed by a physician. This service may not be provided by a paraprofessional.

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	Licensed Speech Therapy
Individual	Licensed Speech Therapy

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech Therapy

Provider Category:

Agency

DRAFT

Provider Type:

Licensed Speech Therapy

Provider Qualifications

License *(specify):*

Licensed per RSMo. 345.010-345.080

Certificate *(specify):*

Other Standard *(specify):*

DHSS Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

Frequency of Verification:

SHCN will verify prior to contract approval and renewal every 3 years; as needed based on service monitoring concerns.
Required professional licenses and certifications are verified monthly by MMAC in accordance with 42 CFR 455.436.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech Therapy

Provider Category:

Individual

Provider Type:

Licensed Speech Therapy

Provider Qualifications

License *(specify):*

Licensed per RSMo. 345.010-345.080

Certificate *(specify):*

Other Standard *(specify):*

DHSS Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider contracted with DHSS and enrolled as a MO HealthNet provider.

DRAFT

Frequency of Verification:

SHCN will verify prior to contract approval and renewal every 3 years; as needed based on service monitoring concerns. Required professional licenses and certifications are verified monthly by MMAC in accordance with 42 CFR 455.436.

Appendix C: Participant Services

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

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

- (●) **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ( ) **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - [ ] **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - [ ] **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - [ ] **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - [ ] **As an administrative activity.** *Complete item C-1-c.*
  - [ ] **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

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):

DRAFT

Prior to allowing individuals to provide direct care services and/or have contact with program participants, Waiver providers are required to perform criminal/background investigations on staff.
Prior to allowing any person who has been hired or contracted through an employment agency as a full-time, part-time, or temporary position to have contact with participants, the BIW provider shall ensure the following background investigations have been completed:
1. Request a criminal record review with the Missouri State Highway Patrol in accordance with requirements of Chapter 43,RSMo;
2. Make an inquiry to the department whether the person is listed on the Employee Disqualification List (EDL) as provided in section 192.2490, RSMo;

Criminal background checks may be submitted directly to the MO State Highway Patrol.
EDL checks may be submitted directly to DHSS.

Providers may satisfy this requirement by conducting an investigation through DHSS, Family Care Safety Registry. The Registry helps to protect waiver eligible individuals by compiling and providing access to background information. The Registry accesses the following background information from Missouri data only and through the following cooperating state agencies:
1) State criminal background records maintained by the Missouri State Highway Patrol
2) Sex Offender Registry information maintained by the Missouri State Highway Patrol
3) Child abuse/neglect records maintained by DSS
4) The EDL maintained by DHSS
5) The Employee Disqualification Registry maintained by the Missouri Department of Mental Health (DMH)
6) Child-Care facility licensing records maintained by DHSS
7) Foster parent licensing records maintained by DSS

Providers are also required to make periodic checks of the EDL, maintained by DHSS, to determine whether any current employee, contractor, or volunteer has been recently added to the list.

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

Monitoring providers for compliance will be conducted during regular monitoring visits and complaint investigations. MMAC verifies every 3 years during the post payment review.

BIW providers are required to perform abuse registry screening on all staff employed by the agency. The MMAC Unit ensures that mandatory investigations have been conducted.

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

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

DHSS is responsible for maintaining the EDL and the Family Care Safety Registry (explained in C-2-a). No person is allowed to be employed to work or allowed to volunteer in any capacity in any BIW who left or was discharged from employment with any other employer due to abuse or neglect to patients or participants and the dismissal or departure has not been reversed by any tribunal or agency. Each BIW provider is required to complete an EDL screening and a criminal record review through the Missouri State Highway Patrol for all new applicants for employment in positions involving contact with participants. The BIW provider is also required to make periodic checks of the EDL to determine whether any current employee, contractor, or volunteer has been recently added to the list. DHSS produces an annual list in January of each year. Updates are added to the web site each quarter which list all individuals who have been added to or deleted from the EDL during the preceding 3 months.

MMAC is responsible for monitoring the waiver providers to assure that mandatory abuse screenings are conducted as required by statute and regulation. This monitoring will be conducted during the audit process.

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

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

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

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

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

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

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

DRAFT

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 SHCN. SHCN staff determines if the provider meets provider qualifications by reviewing documentation that serves as proof of requirements such as licensing, certification, accreditation, training, appropriate staff, etc. If the provider is qualified, BIW staff initiates a DHSS waiver contract with the provider and assists the provider with enrolling as a MO HealthNet provider through DSS, MMAC Unit. All qualified, willing providers are assisted in enrolling as a waiver provider as provided in 42 CFR 431.51. The average time to enroll as a waiver provider is estimated to be 90 days.

An electronic version of the provider application is being developed and will be available on the DHSS/SHCN web site.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

DRAFT

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

Performance Measures

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

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

Performance Measure:
Number and percent of newly enrolled licensed/certified Brain Injury waiver (BIW) providers who met initial waiver provider requirements prior to serving waiver participants. Numerator = Number of newly enrolled licensed/certified BIW providers who met initial waiver provider requirements prior to serving waiver participants. Denominator = Number of newly enrolled licensed/certified BIW providers.

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

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

DRAFT

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

DRAFT

Performance Measure:
Number and percent of licensed/certified Brain Injury Waiver (BIW) providers who continue to meet waiver provider requirements. Numerator = number of licensed/certified BIW providers who continue to meet waiver provider requirements. Denominator = Number of licensed/certified BIW 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):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

DRAFT

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

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

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

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

Performance Measure:
Number and percent of newly enrolled non-licensed/non-certified providers that met initial waiver provider requirements prior to serving waiver participants.
Numerator= Number of newly enrolled non-licensed/non-certified providers that met initial waiver provider requirements prior to serving waiver participants.
Denominator = Total number of newly enrolled non-licensed/non-certified providers.

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

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

DRAFT

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of non-licensed / non-certified waiver providers with a valid participation agreement with DHSS. Numerator = Number of non-licensed / non-certified waiver providers with a valid participation agreement with DHSS. Denominator = Total number of non-licensed / non-certified waiver providers enrolled.

Data Source (Select one):
Other

DRAFT

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

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

Data Aggregation and Analysis:

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

DRAFT

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

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

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

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

Performance Measure:
Number and percent of personal care providers submitting documentation that training requirements for direct care staff were met. Numerator = Number of personal care providers submitting documentation that training requirements for direct care staff were met. Denominator = Total number of personal care providers reviewed.

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

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

DRAFT

		Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

DRAFT

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

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

New applicants who do not meet the initial provider enrollment qualifications are not enrolled as providers. SHCN will complete contracts with providers that meet qualifications and MMAC will complete provider enrollment. MMAC notifies the provider in writing immediately when problems are discovered. MMAC forwards a copy of the notification letter to MHD and SHCN when actions are taken against a provider. Remediation may include recoupment of provider payments or termination of provider enrollment. MMAC and SHCN monitors the provider for compliance. Information is provided to MHD and SHCN (if provided by MMAC) regarding the problems identified, remediation actions required, and changes made by the provider to come into compliance. This information is tracked and trended to ensure problems are corrected.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

DRAFT

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.

There is a $5,000 annual cap for each of the following services: Assistive Technology and Environmental/Home Modifications. The DMH waivers were reviewed for some of the same services that are being offered through this waiver. Since the waiver has a rehabilitation focus rather than maintenance, that also was considered. Missouri outreached to therapists for assistance in determining the average length of time for therapy when calculating the cost limit. The cap of Assistive Technology and home modifications were based upon review of other DMH waivers.

☐ **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.

DRAFT

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.

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

The State believes the BIW settings are compliant with the HCBS Final Rule Settings criteria as participants will be making the choice to live in their own homes, not homes that are provider owned or leased, and not in a residential setting. Participants are able to receive services in the comfort of their own homes without restriction of access to the community.

MHD has found that BIW 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 BIW. All services in the BIW are administered and received in the participants' homes or clinic settings at the choice of the participant/treatment team. These services are administered without restricting the participant's access to the community. Participants enrolled in the BIW live in the greater community to the same degree as individuals not receiving Medicaid HCBS. These homes are owned/rented by the participant/caretaker.

Since the waiver is rehabilitation focused vs. maintenance focused, the participant may progress to receive some services outside the home in professional medical clinic/office settings. The professional medical clinic/office settings will be the same professional medical clinic/office settings that are accessed by individuals in the greater community not receiving Medicaid HCBS. The State did not want to limit participants to receive services only in their home if they choose to go to a professional medical clinic or office setting if that is part of their treatment plan.

BIW staff will make an initial home visit to ensure the participant’s residence is compliant with HCBS standards specifically noting none of the exclusionary settings are applicable at the time of the home visit prior to enrollment and annually thereafter. BIW staff reviews services and service delivery at the bi-annual treatment plan meetings and discusses with participant during monthly phone calls. Participants are not restricted, have access to the community, and can receive services in home or in clinic settings. SHCN will ensure settings remain in compliance during annual home visits and during monthly calls with participants and/or providers. MHD verifies the monitoring during quarterly and yearly oversight reporting.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the

development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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 he/she 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 identifying the following:

- Concerns, priorities, and resources of the participant and/or responsible party
- Outcomes or changes the participant and/or responsible party wants to occur
- Services needed to address the identified outcomes
- Method, duration, and location of services
- Service providers
- Funding resources to cover the cost of the services
- Effective date for the initiation of services

A home or hospital visit shall be made to develop the Plan of Care. The complexity of the plan depends on the needs of the participant. The home or hospital visit will consist of the following:

- Schedule a contact with the participant and/or responsible party to explain the service coordination process and to develop the Plan of Care.
- Promote participation in the development of the plan. Encourage the participant and/or responsible party to discuss their concerns and priorities.
- Assist the participant and/or responsible party in identifying their resources. Resources include personal strengths, weaknesses, preferences, community/family support, coping skills, access to transportation, financial resources (such as private insurance, Medicaid/Medicare, or SSI eligibility) and who controls the participant's finances.
- Identify other agencies/providers who are involved in providing services to the participant. 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.
- Provide information about other resources and help the participant and/or responsible party to identify resources that might be helpful.
- Help the participant 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 the waiver participant. Help the participant and/or responsible party to identify the services needed, to meet the identified outcomes.
- 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.
- 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.
- Provide a copy of the Rights and Responsibilities to the participant and/or responsible party, including the process to request a Fair Hearing, and the BIW staff contact information.

Appendix D: Participant-Centered Planning and Service Delivery

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 months by BIW staff, family, health care team members, and anyone the participant and/or responsible party requests.
B) BIW staff completes a Service Coordination Assessment annually and the Participant Assessment Form, Rehabilitation Assessment Form, LOC, 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 Form is discussed, as are services and provider options.
D) Through discussion and participation, the participant and/or responsible party offer input and voice strengths, concerns, preferences, priorities, and goals during the development of the plan.
E) BIW staff is responsible for coordination of services. Qualified providers are identified through availability and participant and/or responsible party choice.
F) BIW staff, 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 revised/updated every six months during face to face interview with particpant and re-written annually and updated as needed. The participant and/or responsible party is encouraged to contact BIW staff when changes in the plan are needed or they have concerns regarding their care and/or services.

DRAFT

Appendix D: Participant-Centered Planning and Service Delivery

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.
BIW staff 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 6 months.

2. Participant assessment of medical needs.
BIW staff 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.
BIW staff requests and reviews medical reports as needed to identify potential risks and needs. BIW staff 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 is offered to complete an emergency plan. Emergency preparedness plans are developed by the participant and/or responsible party, specific to the participant's needs. It is the participant's and/or responsible party's responsibility to take the steps outlined in the plan that they have prepared. General topics of an emergency preparedness plan could include plans for getting the participant to safety in the event of fire, tornado, flood, and long term power outage.

Caregiver backup plans are a part of the emergency preparedness plan, which is part of the service planning process. BIW participants receive care in their homes and one of the main premises of enrollment is that the participants have adequate natural supports if/when provider agencies are unable to provide staff for the authorized services. BIW staff reviews the plan with the participants and/or responsible parties to ensure the safety of the participants on an ongoing basis.

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 BIW staff. SHCN has access to MHD Information Systems with enrolled provider information for BIW services. SHCN maintains a list of MHD enrolled providers by region and/or county. The appropriate list of providers in the region/county in which the participant lives is given to the participant and/or responsible party at the initial assessment home visit, and as requested. Participants and/or responsible parties are asked to choose their service provider and the Provider Choice Form is completed.

When more than one provider of service is enrolled as a waiver provider, the individual or legal guardian is given a choice among eligible providers. BIW staff educates and informs participants and/or responsible parties regarding eligible providers of services during the annual planning process and at any time as needed. Documentation of education and choice of providers must be included in the annual plan. A list of eligible providers for the given service is provided along with the Client Choice Statement. BIW staff that are providing service coordination is responsible for ensuring participant choice of provider statements are obtained and maintained in the participant's record.

SHCN makes every effort to build provider capacity in rural areas. SHCN works on provider development in areas of identified needs. If there are limited providers available for a chosen service the BIW staff will work closely with the individual to identify other providers that would be willing to provide the needed service in the area of the state where the individual resides.

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 Brain Injury Manager and is available to the MHD.

BIW staff develops the initial service plan and reviews the service plan no less than annually. A change to the service plan may be requested by anyone, including the participant, when there is a change in the participant's needs. However, all service plan changes are subject to the review and approval of BIW staff and include discussion with the participant.

Additionally, SHCN staff completes a 100% of record reviews, no less than annually, on an ongoing basis to assure service plans are completed in accordance with waiver policies and procedures. Reports are produced and sent to MHD no less than annually which document the outcome of the reviews. MHD will review the report no less than annually. Supporting documentation will be available to MHD upon request.

In addition to the annual review performed by SHCN, MHD also conducts their own review based upon 25 randomly selected participants or 100% of records if less than 25. The review by staff from the MHD ensures individuals receiving waivered services had a service plan in effect for the period of time services were provided. The review process also ensures that the need for services that were provided was documented in the service plan, and that all service needs in the plan were properly authorized.

At any time, MHD may conduct a review of the service plan, making the service plan subject to the approval of MHD, the state Medicaid agency. This would normally be conducted through review of reports generated by SHCN, to negate the need for redundancy and duplication of efforts related to record reviews.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

DRAFT

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.

DRAFT

a. Monitoring and implementation of the Plan of Care and participant health and welfare is the responsibility of BIW staff and the provider agency. The provider agency communicates with the participant's physician and/or BIW staff and monitors the provision of services to ensure they are in accordance with physician's orders.

b-c. The Plan of Care and provision of services are monitored through monthly contacts by BIW staff with the participant and/or responsible party. Satisfaction with authorized services is addressed in these contacts and the participant and/or responsible party is given the opportunity to report concerns and/or complaints. The participant and/or responsible party is provided with the Rights and Responsibilities annually, which includes information on how to initiate the process to appeal decisions about services authorized. An in-home visit is performed every 6 months with a review of the Plan of Care. The plan is revised/updated every 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 referrals, and attempts to secure difficult-to-obtain services.

Services meet the needs of the participant by documentation of stability of health (lack of hospitalizations, physician visits, etc.) and reported participant satisfaction. Satisfaction surveys are conducted annually.

Back-up plans are proven 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 parties exercise free choice of providers. The Client Choice Statement Form 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, 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 Brain Injury Manager reviews and approves all participants' Plans of Care. BIW staff tracks all service plan completed/revision dates and the Brain Injury Manager reviews all plans that have been revised. The provider, participant, or BIW staff may request a meeting to discuss changes in circumstances which would result in service plan revision. Service plans would be revised accordingly. BIW staff would review/approve, as appropriate, and submit to the Brain Injury Manager. The Brain Injury Manager would review/approve, as appropriate.

In addition, unusual or unexpected events, concerns, and complaints are reported to the Brain Injury Manager. The Brain Injury Manager, with BIW staff, provides effective follow-up within 1 working day of the notification and resolution no later than 10 working days. A confidential event report is completed by BIW staff. BIW staff or Brain Injury 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, LOC, Client Choice, as well as, health and welfare requirements. Annual reports are tracked and trended to identify any problems and determine needed remediation. BIW staff provides follow-up to MHD on the findings and will put 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of service plans that identify and address the participant's assessed needs. Numerator = Number of service plans that identify and address the participant's assessed needs. Denominator = 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

DRAFT

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

Data Aggregation and Analysis:

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

DRAFT

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

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

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

Data Aggregation and Analysis:

DRAFT

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

Performance Measure:
Number and percent of service plans indicating all personal goals have been assessed and addressed in the service plan. Numerator = Number of service plans indicating all assessed personal goals have been addressed. Denominator = 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☒ **Annually**	☐ **Stratified**

DRAFT

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

Data Aggregation and Analysis:

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

DRAFT

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 waiver participants whose individual service plans included biannual home visits and monthly phone calls to participants. Numerator = Number of waiver participants whose individual service plans included biannual home visits and monthly phone calls. Denominator = Total 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

DRAFT

Data Aggregation and Analysis:

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

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

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

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

DRAFT

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

Data Aggregation and Analysis:

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

DRAFT

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of service plans that were reviewed and revised to address changing needs of the participant. Numerator = Total number of service plans that were revised to address changing needs of the participant. Denominator = Total 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

DRAFT

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service plans that were reviewed on or before the participant's annual waiver review date. Numerator = Number of service plans that were reviewed on or before participant's annual waiver review date. Denominator = 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

DRAFT

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

Data Aggregation and Analysis:

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

DRAFT

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participants who received services by type, scope, amount, frequency, and duration meeting the needs of the participant, identified in their service plan. Numerator = Number of participants who received services by type, scope, amount, frequency, and duration meeting the needs of the participant identified in their service plan. Denominator = 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

DRAFT

Data Aggregation and Analysis:

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

DRAFT

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

Performance Measures

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

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

Performance Measure:
Number and percent of participant records that document the participant was offered choice of waiver services and providers. Numerator = Number of participant service plans that document the participant was offered choice of waiver services and providers. Denominator = 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

DRAFT

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The Brain Injury Manager addresses any issues related to the Plan of Care immediately with BIW staff. BIW staff is required to take appropriate corrective action.

BIW staff will respond to the Brain Injury Manager's request to resolve the problem by providing the Brain Injury Manager with the corrective action taken. The Brain Injury Manager assures the corrective action submitted by BIW staff was implemented.

General methods of remediation may include, but not limited, to service plan revisions, re-training of staff, changes in policy or procedure.

The Brain Injury Manager maintains a "Remediation Log" which identifies the DCN, BIW staff, deficiency, corrective action needed, date discovered, date remediated, and the date that a copy of the correction was received by the Brain Injury Manager.

If it is determined that waiver services were not provided in accordance with the service plan, SHCN will request information from the provider as to why services were not provided as specified in the service plan. General methods of remediation may include provider training and/or service plan changes.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

DRAFT

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

DRAFT

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.

DRAFT

During the assessment process, BIW staff provides each participant and/or responsible party with a Client Choice Statement and a list of qualified providers. The participant's and/or responsible party's choice of a qualified provider is documented. Participant choice of HCBS vs. institutional services is documented on the Client Choice Statement. The Client Choice Statement is reviewed and signed by the participant and/or responsible party acknowledging their right to choice on this form. The Client Choice Statement is reviewed with the participant and/or responsible party during the initial service planning process and annually thereafter. BIW staff maintains a copy in the participant record and provides a copy to the participant and/or responsible party.

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."

When services are reduced, terminated, or denied, the participant is given written notification by BIW staff that includes their appeal rights, process to request a hearing, and the process for maintaining services. The address and phone number for MHD Participant Services is provided in this letter. Copies of notices of adverse action or fair hearing requests are maintained in the participant record.

The participant and/or responsible party is given verbal and written information in the Rights and Responsibilities, the hearing process is explained by BIW staff, and the Rights and Responsibilities is signed by the participant and/or responsible party upon enrollment and annually. Anytime the participant and/or responsible party does not agree when services are changed, reduced, or denied, BIW staff explains the appeal process and a letter is mailed to the participant and/or responsible party stating 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. BIW staff is available to explain the appeals hearing process anytime the participant and/or responsible party has questions or concerns or has difficulty in notifying the Participant Hearings Unit.

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).

DRAFT

Critical incidents include abuse (physical, sexual, or emotional; exploitation; misappropriation of funds/property) and neglect (self or by others). Missouri statutes include a universal reporting mandate, 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; 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 number (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 SHCN document upon initial assessment and bi-annually, by BIW staff. This document includes definitions of abuse, neglect, and exploitation and examples to assist BIW staff 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 BIW staff 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 1-800-392-0210."

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.

DRAFT

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 DSDS Central Registry Unit (CRU) 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 BIW RN/PHN if it 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 Brain Injury Manager reviews all confidential event reports and provides consultation to BIW staff regarding

reporting and follow-up documentation. Events are reported to the Brain Injury Manager immediately upon notification that abuse, neglect, or exploitation has occurred or been alleged. BIW staff documents details on the confidential event report and sends to the Brain Injury Manager. BIW staff calls the Hotline to also inform them that BIW is providing services to the participant and is available to the CRU, if needed, during the investigation. BIW staff requests that the DSDS staff notify BIW staff 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 confidential event report indicating whether the timeframe for the investigation was/was not met is submitted to the Brain Injury Manager. The Brain Injury Manager maintains an event log and determines the number and percent of waiver participants who have had a confidential 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. BIW 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 confidential 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 3 days of their request. The letter states that their request has been received and records will be provided in approximately 45 days.

The Brain Injury Manager reviews all Death Notification forms and provides consultation to the BIW staff regarding follow-up documentation. Participant deaths are reported by BIW 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 BIW was notified, and other comments. The Brain Injury 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.

DRAFT

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. The “periodic reviews of all other reports” are reviews completed by an investigative supervisor for any report that is associated with a hotline investigation involving the preparation for a court hearing or copies of records requested by authorized individuals. These reports are completed on an “as needed basis.” 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 on-going 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. Reports are provided to the State Medicaid Agency when the State Medicaid Agency requests them during their annual record review process.

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of restraints**

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

All waiver services are performed in the participant's home with the exception of therapies, behavior analysis, and neuropsychological evaluation which may be provided in a clinic setting. Applied Behavior Analysis could also occur in another natural environment. BIW staff makes monthly phone contact with the participant and/or responsible party, as well as, face to face visits bi-annually. The suspected inappropriate use of restraints or seclusion would be detected through assessment, observation, and communication. Waiver providers and BIW staff would recognize the use of restraints or seclusion and are mandated to report such. BIW staff reviews documentation in the participant's file, specifically reviewing for unauthorized restraint and seclusion. Suspected inappropriate use of restraints or seclusion would be documented and reported to the CRU at DHSS if abuse, neglect, or exploitation is suspected.

○ **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 with the exception of therapies, behavior analysis, and neuropsychological evaluation which may be provided in a clinic setting. Applied Behavior Analysis could also occur in another natural environment. BIW staff makes monthly phone contact with the participant and/or responsible party, as well as, face to face visits bi-annually. BIW staff reviews documentation in the participant's file, specifically reviewing for unauthorized restraint and seclusion. Suspected inappropriate restrictive interventions would be documented and reported to the 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.

DRAFT

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

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of seclusion**

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

All waiver services are performed in the participant's home with the exception of therapies, behavior analysis, and neuropsychological evaluation which may be provided in a clinic setting. Applied Behavior Analysis could also occur in another natural environment. BIW staff makes monthly phone contact with the participant and/or responsible party, as well as, face to face visits bi-annually. The suspected inappropriate use of restraints or seclusion would be detected through assessment, observation, and communication. Waiver providers and BIW staff would recognize the use of restraints or seclusion and are mandated to report such. BIW staff reviews documentation in the participant's file, specifically reviewing for unauthorized restraint and seclusion. Suspected inappropriate use of restraints or seclusion would be documented and reported to the 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)

DRAFT

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.

DRAFT

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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

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

Performance Measures

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

DRAFT

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 where the participant/responsible party received information/education on how and to whom to report abuse, neglect, exploitation (ANE) and other critical incidents. Numerator = Number of records where the participant/responsible party received information/education on how and to whom to report ANE and other critical incidents. Denominator = 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

DRAFT

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant records that document the participant or responsible party was provided information on who to contact regarding complaints. Numerator = Number of participant records that document the participant or responsible party was provided information on who to contact regarding complaints. Denominator = 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

DRAFT

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

Data Aggregation and Analysis:

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

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

DRAFT

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

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

Data Aggregation and Analysis:

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

DRAFT

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants with an Event Report resulting in an investigation initiated within required timeframes. Numerator = Number of waiver participants with an Event Report resulting in an investigation initiated within required timeframes. Denominator = Number of Event Report investigations reviewed.

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

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

DRAFT

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

Data Aggregation and Analysis:

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

DRAFT

Performance Measure:
Number and percent of waiver participant hotline investigations that were resolved and closed within required timeframes. Numerator = Number of waiver participant hotline investigations that were resolved and closed within required timeframes. Denominator = Number of hotline investigations reviewed.

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

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

Data Aggregation and Analysis:

DRAFT

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

Performance Measure:
Number and percent of investigations regarding unexplained deaths of waiver participants reviewed and closed within required timeframes. Numerator = Number of investigations regarding unexplained deaths of waiver participants reviewed and closed within required timeframes. Denominator = Total number of unexplained death hotline investigations reviewed.

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

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

DRAFT

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of critical incidents including Abuse, Neglect and Exploitation (ANE) and unexplained deaths that the necessary corrective actions were taken. Numerator = Number of critical incidents including ANE and unexplained deaths that the necessary corrective actions were taken. Denominator = Total number of reports reviewed.

DRAFT

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

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

Data Aggregation and Analysis:

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

DRAFT

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of unauthorized use of restrictive interventions that were appropriately reported. Numerator = Number of unauthorized use of restrictive interventions that were appropriately reported. Denominator = Number of unauthorized use of restrictive interventions reviewed.

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

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

DRAFT

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

Data Aggregation and Analysis:

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

DRAFT

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 records with documentation of a completed neuropsychological evaluation for participants who upon initial assessment required an evaluation. Numerator = Number of records with documentation of a completed neuropsychological evaluation for participants who upon initial assessment required an evaluation. Denominator = Number of participant records that required an evaluation.

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

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

DRAFT

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

DRAFT

Performance Measure:
Number and percent of participants whose Person Centered Care Plan (PCCP) addresses their health needs. Numerator = Number of participants whose PCCP addresses their health needs. Denominator = Number of PCCPs reviewed.

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

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

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

Data Aggregation and Analysis:

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

DRAFT

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

The Brain Injury Manager addresses any issues with BIW staff related to health, welfare, and safety immediately. The Brain Injury Manager maintains an event log and follows up to ensure the problem was remediated. Individual issues are included in the annual waiver report.

The Brain Injury Manager reviews all confidential event reports and provides consultation to BIW staff regarding reporting and follow-up documentation. Events are reported to the Brain Injury Manager immediately upon notification that abuse, neglect, and exploitation has occurred or been alleged. BIW staff documents details on the confidential event report and sends to the Brain Injury Manager. BIW staff calls the Hotline to also inform them that BIW is providing services to the participant and is available to the CRU, if needed, during the investigation. BIW staff reviews 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 confidential event reports may be completed for problems not resolved, with additional contact to the CRU. BIW will contact CRU to check status of any hotlines on participants and request that the DSDS staff notify the Brain Injury Manager if the investigation of the event was or was not completed within the appropriate timeframe and if the investigation was closed within 60 days (per DSDS policy).

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities*

DRAFT

of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

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

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

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

DRAFT

No less than annually, MHD Program Operation staff and BIW staff meet to discuss the Quality Improvement Strategy described throughout the Brain Injury Waiver (1406), Adult Day Care Waiver (1021), Aged and Disabled Waiver (0026), Independent Living Waiver (0346), Medically Fragile Adult Waiver (40190), and the AIDS Waiver (0197).

At this time, BIW staff and MHD Program Operations staff jointly review the performance measures and analyze corresponding reports generated by both agencies. MHD and BIW staff 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 BIW staff based on the reports for each performance measure using the number and percent of compliance.

Recommendations for system change may come from either agency; however, MHD will approve any changes to the Quality Improvement Strategy specified in the waiver application. Any changes in the Quality Improvement Strategy in the waiver application are implemented and monitored, as appropriate, and would be included with renewal of the waiver or submitted as an amendment.

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

Although individual problems are remediated upon discovery, performance measures that are significantly lower than 100% may need to be addressed as a systemic issue. Implementation of system improvement will be a joint effort between BIW staff and MHD. System change related to delegated activities will be the responsibility of BIW staff 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 BIW staff will analyze the effectiveness of system improvement activities through the quality improvement strategy reports and or additional reports that may be recommended by BIW staff and or MHD when significant areas of concern are identified.

The QIS Spans all Missouri HCBS DHSS waivers, but data is stratified for each respective waiver.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

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

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

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

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

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

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

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

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

The Service Coordination Assessment is a continuous activity that begins when the referral/application is received and continues throughout the service coordination process. Comprehensive assessments are due annually but no later than thirteen (13) months from the last completed assessment.

The assessment information is obtained through the use of the Service Coordination Assessment (SCA). The initial SCA must be completed within thirty (30) calendar days of initial enrollment during a face to face visit with the participant/family. If the SCA was completed on initial visit and the enrollment process takes greater than six months, a new assessment is required within 30 days of actual enrollment.

Information obtained during the comprehensive assessment will be used in the development of the service plan.

Quality Assurance questions are reviewed during the comprehensive assessment.

DRAFT

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).*

DRAFT

Providers are required to maintain financial records and service documentation on each waiver participant, including the name of the participant, the participant's MHD identification number, the names of the individual attendants who delivered the service, the date that the service was rendered, and the units of service provided. Providers are not required to have independent audits performed. Services provided through the BIW must be prior authorized by state staff; prior authorizations are based on the agreed upon services established during the service planning process.

The provider subsequently receives payment directly from MHD as reimbursement. MHD makes a Remittance Advice indicating the disposition of billed claims available to the provider.

The MMAC Unit within the DSS conducts periodic compliance audits in which the documentation of services provided is reviewed to ensure that services billed to MHD were provided and documented as required per state regulation. The selection of participants is determined by what providers are selected to be audited during the audit period timeframe. It is MMAC's intent to review providers on a rotating basis, every three years. Providers are divided into thirds and approximately 1/3 of the providers are reviewed each year. A provider with a history of problematic billing or complaints may be "spot checked" regarding those focused areas, in addition to receiving regular periodic audits. Reviews are performed on-site. A desk audit may be considered for providers with few participants in an outer area of the state when it is not economically feasible to travel long distances to the provider's location to obtain a small number of records. A desk audit entails requesting records by mail or fax. Providers are generally given 15 business days to produce records for a desk audit. The provider may then mail, fax, or email the requested records. Other than the requested records being sent in by the provider, the desk audit process is the same as off-site audits as stated for the following: The same in-depth review of records is completed and the same types and numbers of records are collected. Providers will receive a call and a fax 24 hours prior to the audit. The fax contains a notice to audit and a partial list of participant names that will be included in the audit. Once the audit has been finalized the provider will receive a letter outlining the violations and sanctions. The provider then has 30 days to appeal and 45 days to submit a plan of correction. If the provider is found to not have any violations, the provider will receive a "No Error Letter" stating that the provider did not have any violations.

Audits are conducted every 3 years. However, reviews may be conducted sooner if a complaint is received or if a follow-up audit on a provider that had major violations is completed.

Corrective action plans submitted by providers are reviewed and accepted or denied. Providers found to have egregious errors, both in type and/or volume, are monitored periodically and, if it appears from claims data the problem has not been resolved, another audit may occur, or an investigation may be opened, or both.

Each year, MMAC prepares a work plan for areas of focus. Input includes the OIG work-plan, CMS guidance and publications, trends, complaints and referrals, continued areas of non-compliance, and other factors. MMAC has a clinical services, HCBS, behavioral health, and mental health services review groups.

Reviews of HCBS providers are done at least once every 3 years. Reviews of all other providers are chosen based upon one or more factors, such as: work-plan, complaints/referrals/hotlines from the public, participants, other providers, other agencies such as licensing boards, DHSS, DMH, Medi-Medi contractor, or the Attorney General's office, length of time since last audit, amount billed to the state, aberrant or quickly trending upward billing, analytic results showing suspicious or aberrant billing patterns and follow up to prior audits.

Statistically valid samples are generally not used to determine which providers will be reviewed. The total number of HCBS providers is determined every year and divided into thirds and approximately 1/3 of the providers are reviewed each year. Should a current HCBS provider also be a Brain Injury provider, the review of the BIW provider would occur at that time; therefore, 100% of BIW providers will be reviewed at least every 3 years. Utilization reports and trends are monitored between audits, and complaints or referrals can trigger an audit.

Typically, audits are not performed on new providers within their first year. However, providers that are included in an audit with less than a year's worth of information would have all existing documentation reviewed.

Review results statistics are available upon request.

Providers have the responsibility of ensuring they have adequate documentation to support services prior to the filing of claims to MHD for reimbursement.

The State requires providers to retain documentation for 5 years, but generally utilizes a 3 year look back period due to

availability of billing records. Audits generally encompass a period of 1 year or less.

The audit trail consists of documents located in the individual participant case records, the database utilized for authorization of services, MHD, and the providers. The case records contain the service plan (basis for the prior authorization). Corresponding information is maintained in the SHCN information system.

BIW expenditures are subject to the State of Missouri's Single State Medicaid Audit conducted by the Missouri State Auditor's office.

Documentation that support provider billing are reviewed such as service authorizations and provider monitoring logs. Verification of correct names, and the in and out times, etc. are also reviewed. Background screening is reviewed as part of MMAC's audits/reviews. Some provider types are required to do criminal background checks and some are required to utilize the Family Care Safety Registry (FCSR) to do their checks, and some employees are required to be registered. This varies depending upon the HCBS provider type, and other provider types, as well. MMAC ensures employees are properly registered or have properly disclosed, and that initial and periodic screenings are performed, and that Good Cause Waivers (GCW) are applied for and received as necessary. As necessary, employees can request a GCW from DHSS' Division of Regulation and Licensure (DRL). State Statues requires regulated health care employers to obtain background screenings prior to hiring an employee; to include the FCSR. An individual with a certain type of criminal history finding identified in their background screening cannot be hired by these employers. An individual who has been disqualified from employment has the right to apply for a GCW, which, if granted, would not correct or remove the finding, but would remove the hiring restriction and allow the individual to be employed. Verification of screening is requested and reviewed to see if the employees have been screened and that the screening was done timely. The participant's current plan of care and progress notes are reviewed to verify that the plan is being followed and that notes are being maintained. MMAC also audits/reviews for licensure qualifications, age qualifications, training and orientation qualifications, and other program specific qualifications, such as family members being personal care attendants or not. The scope of this process is not different as mentioned in other areas. Documents are either sent in to MMAC by the provider (desk review) or scanned while on-site at the provider's location (on-site review). MMAC personnel may access participant care plans through DCPH database. MMAC personnel are also independently able to verify employees' registration and screening through the FCSR. However, MMAC expects the providers to have access to paper copies of participants' care plans and expects the providers to have documentation of employee registration and screening (and application and granting of a Good Cause Waiver, if necessary.) MMAC also expects to see any and all other documentation to support the provider's billing, such as time sheets, physician's orders, nurse visit reports, etc.

If the provider is found to not have any violations, the provider will receive a "No Error Letter' stating that the provider did not have any violations. If the provider is found to have violations MMAC will include the violation in its list of violations sent to the provider in its final determination letter (audit findings).

MMAC then reviews its State Regulation pertaining to sanctions (13 CSR 70-3.030) to determine the appropriate sanction. Providers may have the improperly paid money recouped or they may face more serious sanctions such as suspension or termination. Providers may face less serious sanctions in situations where the money was properly paid (there was no adverse finding rendering the employee unqualified but the provider failed to timely screen the employee, for instance.)

During an audit, MMAC checks every single employee who has contact with every/any participant who is part of the audit. There is no sampling on this issue. MMAC will sample training and orientation documents during an audit, choosing the number dependent upon the number of employees.

Whether MMAC conducts a "desk review" or an on-site audit, the auditors collect or receive documents from the providers and those are compared to the claims the providers submitted (their billing) and the participant care plans. MMAC will determine if the services or products were authorized, if they were properly documented, if the billing is appropriate, and MMAC will also contact participants to determine if they received the services or products, when any question exists regarding actual provision of services.

All procedures described are part of the DSS periodic audit conducted by MMAC and not a separate post-payment procedure.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver claims paid for services that are included in the approved waiver. Numerator = Number of waiver claims paid for services included in the waiver. Denominator = Total number of claims paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS/CIMOR/DCPH Database

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

DRAFT

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers with supporting documentation of services rendered for claims billed by the provider. Numerator = Number of providers with supporting documentation of services rendered for claims billed by the provider. Denominator = Total number of providers reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Operating Agency Report and MMIS

DRAFT

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

Data Aggregation and Analysis:

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

DRAFT

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

b. Sub-assurance: The 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 claims that paid at or below the rate specified in the MMIS Procedure, Drug and Diagnosis (PDD) file. Numerator = Number of claims that paid at or below the rate specified in the MMIS PDD file. Denominator = Total number of claims reviewed

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

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

DRAFT

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

Data Aggregation and Analysis:

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

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

DRAFT

b. Methods for Remediation/Fixing Individual Problems

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

State financial oversight exists to ensure claims are coded and paid in accordance with the reimbursement methodology in the approved waiver. Claims payment issues are the responsibility of MHD. MHD works to resolve payment issues as they are identified by MHD or SHCN. Remediation occurs through changes in policy, procedure, CIMOR or MMIS system edits, or through the finalization of 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 generates 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.

When an overpayment or underpayment has occurred, MHD recycles claims to pay or recoup appropriate funds.

MMAC is responsible for provider reviews and identifying incorrect billings due to inadequate documentation, coding or unit errors, or other findings.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

DRAFT

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The reimbursement rates for the BIW were established based on waiver rates from other waivers using similar waiver services. The reimbursement rates for these services are subject to and will be determined by the State Legislature, through the State of MO annual budgeting/appropriation process. The state legislature works independently with legislative budgetary and research staff and the input of the Missouri brain injury provider industry and participants to develop rate changes during the annual appropriations process and development of the State budget.

The public is able to testify at annual appropriation hearings conducted by the State House of representatives (MO HoR) and State Senate appropriation committees to provide input on reimbursement rates.

All hearing notices are posted in the State Capitol. Additionally, the House and Senate each have a website dedicated to the legislative session activity, which includes notification of hearings.

Special interest groups also track and monitor these hearing so that these members have the opportunity to testify.

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

The Missouri State Legislature employs research staff who work in coordination with provider industry representatives and State agencies to determine inputs for development of rates. The MO HoR has a standing Appropriations Committee for DHSS, DMH, and DSS. This committee develops initial recommendations for rates and this information is sent to the standing Select Committee on Budget for final decisions regarding rates being sent for a vote decision before the MO HoR. In the Missouri Senate, there is a standing Appropriations Committee which reviews information gathered by its members to determine rates, which then go before the Senate for vote.

Rates for waiver services are historically based on four factors. These four factors are the Missouri hourly minimum wage, gas prices for the Midwest per gallon, the hourly amount for BIW services, and the Consumer Price Index. The State Legislature has the opportunity to ask questions from state agencies during the appropriations process.

Rates are reviewed annually during each legislative session (January - May) by the State Legislature. The State Legislature makes the decision regarding any updates at this time. Both MHD and DHSS provide historical utilization data to the Governors' budget office and appropriation committee that is used to apply a per unit increase to waiver services.

The rates established by the State Legislature are statewide rates; it does not vary by provider. Current reimbursement rates can be found on MHD's website at http://dss.mo.gov/mhd/providers/pages/cptagree.htm. Information regarding payment rates is available upon request by the participant, through the MHD Participant Services Unit or online at the MHD website. Requests may be made in writing to the MHD or SHCN, by e-mail 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 BIW staff. The prior authorization is entered into the CIMOR system. Providers of services bill claims for services directly to the CIMOR system for claims processing. All claims are sent from CIMOR to MMIS and payment is 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:*

DRAFT

Services provided through the BIW must be prior authorized by state staff. Prior authorizations are based on the agreed upon services established during the service planning process. BIW staff determines participants' eligibility for waiver services and develop/finalize the service plan. Based upon the participant's approved service plan, services are then prior authorized. This information is then transferred to the CIMOR system as a prior authorization for approved services against which all claims for payment from providers are compared. A copy of the authorization is provided to the provider selected by the waiver participant; therefore, the provider is aware of the authorization. Providers bill for services directly into the CIMOR system. The authorization in CIMOR contains the waiver specific procedure code and the number of units authorized per month for the participant. CIMOR then sends claims to the MMIS system for payment. The MMIS system incorporates an edit function that ensures payment for services are only to the provider for dates of service on which the participant is Medicaid eligible and to providers who are enrolled on the date a service is delivered. No reimbursement will be made for units billed by the provider in excess of the authorized amount. Each date of service must match or fall within the from/through dates on the appropriate line of the authorization. Each time a claim is processed and paid, the number of units reimbursed to the provider is deducted from the number of units authorized. The MMAC within the DSS conducts periodic compliance audits in which the documentation of services provided is reviewed to ensure that services billed to MHD were provided and documented as required per regulation. MMAC may arrange to conduct some interviews with waiver participants during monitoring. Discussion of whether services were actually delivered is held during these interviews. When investigating a complaint, MMAC staff will also be verifying that services are delivered as reported. Providers are required to have adequate documentation of service delivery prior to filing claims for reimbursement through CIMOR.

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:

DRAFT

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.

DRAFT

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.

DRAFT

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

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

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

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

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

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

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

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

DRAFT

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

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

Appendix I: Financial Accountability

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

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

☐ ***Appropriation of State Tax Revenues to the State Medicaid agency***

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

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

The home and community based appropriations belong to the DHSS. Claims are processed through the MMIS and adjudicated for payment. During the adjudication process, the DSS/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 MHD.

☐ ***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:

DRAFT

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:

DRAFT

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:

DRAFT

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.*

DRAFT

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	22227.99	14324.00	36551.99	48387.00	12022.00	60409.00	23857.01
2	23385.45	14697.00	38082.45	49645.00	12334.00	61979.00	23896.55
3	23946.33	15079.00	39025.33	50936.00	12655.00	63591.00	24565.67

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 7)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	20	20
Year 2	20	20
Year 3	20	20

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 7)

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

Average length of stay is predicted to be around 308 days. Since this is a new waiver for Missouri, Missouri reviewed other states with similar waiver services. Missouri reviewed 21 states and selected five states (Kansas, Florida, Illinois, New Hampshire, and New Jersey) and averaged their length of stay which calculated to 308 days.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 7)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

DRAFT

Factor D was estimated using other waivers in Missouri that offer the same and/or similar service.

The State utilized a variety of sources to estimate utilization rates. Since this waiver is unique in its service and focus, it was difficult to just use utilization. Since this is a unique service array and focus (rehabilitation), the utilization is the State's best estimate.

The average cost per unit of service is based on the reimbursement rate for the DMH Developmental Disabilities Comprehensive Waiver except for Personal Assistant services which are based on the reimbursement for the Medically Fragile Adult Waiver. Environmental Access and Modification is based on the Illinois and Florida Brain Injury Waivers, Assistive Technology is based on the Money Follows the Person Program cap, and the neurophysiological evaluation rate is based on the State's Adult Brain Injury Program.

To project growth, the State used the market basket rate indicated on Centers for Medicare and Medicaid Services' (CMS) web-site. This practice maintains consistency with other Missouri waivers.

Additionally, the State of Kansas Brain Injury Waiver was reviewed for the same and/or similar service. The average cost per unit was projected forward 2.6% for years 2 - 3 of the waiver.

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:*

To estimate the average annual state plan expenditures for factor D', actual MMIS paid claims data for individuals with a traumatic brain injury diagnosis was utilized. Paid claims data for dates of service July 2016 through June 2017 was used to ensure complete claims data was available. The average annual expenditure for factor D' was projected forward for years 1-3 of the waiver using the market basket rate increase as indicated on CMS' web-site regarding the Skilled Nursing Facility data source points for FY 18 of 2.6%. The market basket data was obtained at the following web address: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html. Medicare Part D is not a factor in our determination of Factor D'.

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

To estimate the average annual nursing facility cost for factor G, the 2018 average nursing facility daily rate of $153.12 was utilized. This rate was multiplied by the estimated average length of stay of 308 days. That total was projected forward for years 2-3 of the waiver using the market basket rate increase as indicated on CMS' web-site regarding the Skilled Nursing Facility data source points for FY 18 of 2.6%. The market basket data was obtained at the following web address: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html.

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:*

To estimate the average annual State Plan expenditures for factor G', actual MMIS paid claims data for individuals in a nursing facility was utilized. Paid claims data for dates of service July 2016, through June 2017 was used to ensure complete claims data was available. The average annual expenditure for factor G' was projected forward for years 1-3 of the waiver using the market basket rate increase as indicated on CMS' web-site regarding the Skilled Nursing Facility data source points for FY 18 of 2.6%. The market basket data was obtained at the following web address: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html. Medicare Part D is not a factor in our determination of Factor G'.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 7)

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	
Personal Care Services	
Applied Behavior Analysis	
Assistive Technology	
Cognitive Rehabilitation Therapy	
Environmental Access and Modification	
Neuropsychological Evaluation	
Occupational Therapy	
Physical Therapy	
Speech Therapy	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 7)

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
Personal Care Services Total:						122310.00
Personal Care Services	1/4 hour	15	1800.00	4.53	122310.00	
Applied Behavior Analysis Total:						35827.52
Adaptive Behavior Treatment by Protocol by Technician	1/4 hour	11	50.00	13.32	7326.00	
Adaptive Behavior Treatment by Protocol Modification	1/4 hour	11	17.50	23.01	4429.42	
Exposure Adaptive Behavior Treatment by Protocol Modification	1/4 hour	9	23.33	23.01	4831.41	
Family Adaptive Behavior Treatment Guidance	1/4 hour	4	100.00	23.01	9204.00	
Behavior Identification Assessment	1/4 hour	12	2.00	23.01	552.24	
Observational Behavioral Follow	1/4 hour	12	27.69	23.01	7645.76	
				GRAND TOTAL:		444559.83
				Total Estimated Unduplicated Participants:		20
				Factor D (Divide total by number of participants):		22227.99
				Average Length of Stay on the Waiver:		308

DRAFT

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Up Assessment						
Exposure Behavioral Follow Up Assessment	1/4 hour	9	7.69	23.01	1592.52	
Adaptive Behavior Treatment Social Skills, Group	1/4 hour	2	68.00	1.81	246.16	
Assistive Technology Total:						60000.00
Assistive Technology	1 job	12	1.00	5000.00	60000.00	
Cognitive Rehabilitation Therapy Total:						26804.91
Cognitive Rehabilitation Therapy	1/4 hour	13	69.73	29.57	26804.91	
Environmental Access and Modification Total:						60000.00
Environmental Access and Modification	1 job	12	1.00	5000.00	60000.00	
Neuropsychological Evaluation Total:						11875.00
Neuropsychological Evaluation	1	19	1.00	625.00	11875.00	
Occupational Therapy Total:						44709.84
Occupational Therapist Individual Therapist	1/4 hour	14	108.00	29.57	44709.84	
Physical Therapy Total:						47903.40
Physical Therapist - Individual	1/4 hour	15	108.00	29.57	47903.40	
Speech Therapy Total:						35129.16
Speech Therapy	1/4 hour	11	108.00	29.57	35129.16	
				GRAND TOTAL:		444559.83
				Total Estimated Unduplicated Participants:		20
				Factor D (Divide total by number of participants):		22227.99
				Average Length of Stay on the Waiver:		308

DRAFT

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 7)

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
Personal Care Services Total:						125550.00
Personal Care Services	1/4 hour	15	1800.00	4.65	125550.00	
Applied Behavior Analysis Total:						41654.37
Adaptive Behavior Treatment by Protocol by Technician	1/4 hour	12	50.00	13.67	8202.00	
Adaptive Behavior Treatment by Protocol Modification	1/4 hour	12	17.50	23.61	4958.10	
Exposure Adaptive Behavior Treatment by Protocol Modification	1/4 hour	10	23.33	23.61	5508.21	
Family Adaptive Behavior Treatment Guidance	1/4 hour	5	100.00	23.61	11805.00	
Behavior Identification Assessment	1/4 hour	13	2.00	23.61	613.86	
Observational Behavioral Follow Up Assessment	1/4 hour	13	27.69	23.61	8498.89	
Exposure Behavioral Follow Up Assessment	1/4 hour	10	7.69	23.61	1815.61	
Adaptive Behavior Treatment Social Skills, Group	1/4 hour	2	67.93	1.86	252.70	
Assistive Technology Total:						65000.00
Assistive Technology	1 job	13	1.00	5000.00	65000.00	
Cognitive Rehabilitation Therapy Total:						32252.03
Cognitive Rehabilitation Therapy	1/4 hour	14	75.93	30.34	32252.03	
Environmental Access and Modification Total:						60000.00
Environmental Access and Modification	1 job	12	1.00	5000.00	60000.00	
Neuropsychological Evaluation Total:						12183.75
Neuropsychological Evaluation	1	19	1.00	641.25	12183.75	
Occupational Therapy Total:						45874.08
Occupational Therapist					45874.08	

GRAND TOTAL:	467708.95
Total Estimated Unduplicated Participants:	20
Factor D (Divide total by number of participants):	23385.45
Average Length of Stay on the Waiver:	308

DRAFT

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Therapist	1/4 hour	14	108.00	30.34		
Physical Therapy Total:						49150.80
Physical Therapist - Individual	1/4 hour	15	108.00	30.34	49150.80	
Speech Therapy Total:						36043.92
Speech Therapy	1/4 hour	11	108.00	30.34	36043.92	
				GRAND TOTAL:		467708.95
				Total Estimated Unduplicated Participants:		20
				Factor D (Divide total by number of participants):		23385.45
				Average Length of Stay on the Waiver:		308

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 7)

DRAFT

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
Personal Care Services Total:						128790.00
Personal Care Services	1/4 hour	15	1800.00	4.77	128790.00	
Applied Behavior Analysis Total:						43301.36
Adaptive Behavior Treatment by Protocol by Technician	1/4 hour	12	50.00	14.03	8418.00	
Adaptive Behavior Treatment by Protocol Modification	1/4 hour	12	17.50	24.22	5086.20	
Exposure Adaptive Behavior Treatment by Protocol Modification	1/4 hour	11	23.33	24.22	6215.58	
Family Adaptive Behavior Treatment Guidance	1/4 hour	5	100.00	24.22	12110.00	
Behavior Identification Assessment	1/4 hour	13	2.00	24.22	629.72	
				GRAND TOTAL:		478926.59
				Total Estimated Unduplicated Participants:		20
				Factor D (Divide total by number of participants):		23946.33
				Average Length of Stay on the Waiver:		308

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Observational Behavioral Follow Up Assessment	1/4 hour	13	27.69	24.22	8718.47	
Exposure Behavioral Follow Up Assessment	1/4 hour	10	7.69	24.22	1862.52	
Adaptive Behavior Treatment Social Skills, Group	1/4 hour	2	68.29	1.91	260.87	
Assistive Technology Total:						65000.00
Assistive Technology	1 job	13	1.00	5000.00	65000.00	
Cognitive Rehabilitation Therapy Total:						34853.15
Cognitive Rehabilitation Therapy	1/4 hour	15	74.64	31.13	34853.15	
Environmental Access and Modification Total:						60000.00
Environmental Access and Modification	1 job	12	1.00	5000.00	60000.00	
Neuropsychological Evaluation Total:						12500.48
Neuropsychological Evaluation	1	19	1.00	657.92	12500.48	
Occupational Therapy Total:						47068.56
Occupational Therapist Individual Therapist	1/4 hour	14	108.00	31.13	47068.56	
Physical Therapy Total:						50430.60
Physical Therapist - Individual	1/4 hour	15	108.00	31.13	50430.60	
Speech Therapy Total:						36982.44
Speech Therapy	1/4 hour	11	108.00	31.13	36982.44	

GRAND TOTAL:	478926.59
Total Estimated Unduplicated Participants:	20
Factor D (Divide total by number of participants):	23946.33
Average Length of Stay on the Waiver:	308

DRAFT