

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:

Medically Fragile Adult Waiver

C. Waiver Number: MO.40190

Original Base Waiver Number: MO.40190.

D. Amendment Number:

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

07/30/21

Approved Effective Date of Waiver being Amended: 07/01/21

2. Purpose(s) of Amendment

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

The purpose of this amendment is to make changes to the eligibility standards for Nursing Facility Level of Care (LOC).

In an amendment to state regulation 19 CSR 30-81.030, Missouri decreased the required point count from 24 to 18 points to qualify for LOC. The criteria used to evaluate individual's ability to meet LOC is modified to ensure the right services, to the right people, in the right setting, at the right time. This includes changes to the specific areas which are considered when determining an individual's ability or inability to function in the least restrictive environment, and the scoring methodology. The change in the criteria will change the population of those that meet LOC. The amount of individuals that will no longer meet LOC vs those that will become newly eligible is undetermined.

Upon approval of the amendment, the updated level of care criteria will be applied to waiver participants at initial evaluation and reevaluation. Performance Measures are not affected by this change.

3. Nature of the Amendment

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

| Component of the Approved Waiver | Subsection(s) |
|--|---------------------------------------|
| Waiver Application | |
| Appendix A Waiver Administration and Operation | |
| Appendix B Participant Access and Eligibility | B-6-d |
| Appendix C Participant Services | C-1/C-3 – PDN service specifications. |
| Appendix D Participant Centered Service Planning and Delivery | |
| Appendix E Participant Direction of Services | |
| Appendix F Participant Rights | |
| Appendix G Participant Safeguards | |
| Appendix H | |
| Appendix I Financial Accountability | |
| Appendix J Cost-Neutrality Demonstration | |

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

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

The LOC model used since 1982 focused on the symptoms rather than the need. With a grant award in 2017, DSDS started the process of changing state regulation 19 CSR 30-81.030. DSDS used national research of best practices, robust stakeholder feedback, testing of the criteria, and public comment. The resulting changes reflect the 21st century medical advancements and growth of Missouri's aging population.

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

1. Request Information (1 of 3)

A. The State of Missouri requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Medically Fragile Adult Waiver

C. Type of Request: amendment

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

3 years 5 years

Original Base Waiver Number: MO.40190

Draft ID: MO.016.05.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/21

Approved Effective Date of Waiver being Amended: 07/01/21

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**Nursing Facility**

Select applicable level of care

Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155

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

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

ICF/IID capable of caring for medically fragile individuals.

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

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

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

The waiver is administered by the SHCN through an interagency agreement with the Single State Medicaid Agency, DSS, MHD. SHCN provides service coordination services for participants served by the waiver.

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

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

3. Components of the Waiver Request

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

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

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

care.

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

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

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

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

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

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

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

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

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

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

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

Geographic Limitation. A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery

methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

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| |
|--|

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery

processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

This information will be provided after public comment period ends.

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

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

7. Contact Person(s)

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

Last Name:

Glenda

First Name:

Kremer

Title:

Assistant Deputy Director

Agency:

Missouri Department of Social Services, MO HealthNet Division

Address:

P.O. Box 6500

Address 2:

615 Howerton Court

City:

Jefferson City

State:

Missouri

Zip:

65102-6500

Phone:

(573) 751-9290

Ext:

TTY

Fax:

(573) 526-4651

E-mail:

Glenda.Kremer@dss.mo.gov

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

Last Name:

Woods

First Name:

Leslie

Title:

Public Health Consultant Nurse, Program Manager

Agency:

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

Address:

P.O. Box 570

Address 2:

920 Wildwood

City:

Jefferson City

State:

Missouri

Zip:

65102

Phone:

(573) 751-6246

Ext:

TTY

Fax:

(573) 751-6237

E-mail:

Leslie.Woods@health.mo.gov

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

Richardson

First Name:

Todd

Title:

| | | | |
|--------------------|---|---------------------------|-----|
| | <input type="text" value="Division Director"/> | | |
| Agency: | <input type="text" value="Department of Social Services, MO HealthNet Division"/> | | |
| Address: | <input type="text" value="615 Howerton Court"/> | | |
| Address 2: | <input type="text"/> | | |
| City: | <input type="text" value="Jefferson City"/> | | |
| State: | Missouri | | |
| Zip: | <input type="text" value="65109"/> | | |
| Phone: | <input type="text" value="(573) 751-6922"/> | Ext: <input type="text"/> | TTY |
| Fax: | <input type="text" value="(573) 751-6564"/> | | |
| E-mail: | <input type="text" value="Leann.Hager@dss.mo.gov"/> | | |
| Attachments | <input type="text"/> | | |

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

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

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Each participant's level of care will be determined upon their annual reassessment. If upon reassessment the participant does not meet the new required LOC, staff will inform them verbally and mail an adverse action notice with a detailed explanation of the denial, including a reference to specific regulation. Each participant's level of care will be determined upon their annual reassessment.

Pursuant to the Code of Federal Regulations (CFR), specifically 42 CFR 431.211 regarding advance notice of an adverse action, unless otherwise specified, any adverse action that results in a change to the case status or changes a prior authorization shall require a ten (10) business day notification prior to the date of the change or closing. Participants will also receive their appeal rights in this notification. If the participant chooses to appeal within the ten (10) day time period services will remain in effect until the hearing decision is received. The participant has ninety (90) business days from the date the adverse action notice is mailed to appeal the decision.

During the verbal notification, participants will be provided with information regarding community options and resources to assist them in making contacts to find other supportive services to remain independent. If participants have the appropriate diagnosis for an ICF/ID waiver, an appropriate referral will be made at that time. All other Medicaid funded HCBS services in Missouri require the participant to meet nursing facility LOC.

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

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

*(Do not complete item A-2)***Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

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

*(Complete item A-2-a).***The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

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

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Missouri Department of Social Services (DSS), MO HealthNet Division (MHD), has developed a Home and Community-Based Services (HCBS) waiver quality management strategy that is used to ensure that the operating agency, the Department of Health and Senior Services (DHSS), Bureau of Special Health Care Needs (SHCN), is performing its assigned waiver operational functions and administrative functions in accordance with the waiver requirements during the period that the waiver is in effect. MHD and SHCN meet quarterly to discuss administrative/operational components of the MFAW. This time is also used to discuss the quality assurances as outlined in the waiver. Through a Memorandum of Understanding that exists between the two agencies, communication remains open and additional discussions occur on an as needed basis.

MHD conducts an analysis of quarterly and annual reports submitted by SHCN to ensure that the operational functions as outlined in A-7 are being implemented in a quality manner. MHD reviews the information to ensure the following assurances are meeting the established outcomes: 1) Level of Care, 2) Plan of Care, 3) Qualified Providers, 4) Health and Welfare, 5) Administrative Authority, and 6) Financial Accountability. A formal report is provided to the SHCN outlining the results of the analysis and listing any areas for improvement. SHCN in turn provides a written corrective action plan for any areas of deficiency, outlining the steps to be taken to ensure the assurances are being met. Goals and timelines are included. MHD works closely with the SHCN to monitor areas of deficiencies, to set goals and establish timeframes for compliance.

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

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

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

Appendix A: Waiver Administration and Operation

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Not applicable

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

Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of policies, procedures, and rules reviewed by MHD, applicable to the waiver. Numerator = Number of policies, procedures, and rules reviewed by MHD, applicable to the waiver. Denominator = Total number of policies, procedures, and rules

released by the operating agency applicable to the waiver.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MHD policy tracking

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

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (<i>check each that applies</i>): | Frequency of data aggregation and analysis(<i>check each that applies</i>): |
|---|---|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |

| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|--|--|
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

Performance Measure:

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

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

If 'Other' is selected, specify:

MMIS

| Responsible Party for data collection/generation <i>(check each that applies):</i> | Frequency of data collection/generation <i>(check each that applies):</i> | Sampling Approach <i>(check each that applies):</i> |
|--|--|---|
| State Medicaid Agency | Weekly | 100% Review |
| Operating Agency | Monthly | Less than 100% Review |
| Sub-State Entity | Quarterly | Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> | Annually | Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |
| | Continuously and Ongoing | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

| | | |
|--|--|----------------------|
| | | <input type="text"/> |
| | Other Specify: <input type="text"/> | |

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of approved amount for services or, if less than approved amount, actual aggregate expenditures for services. Numerator= Aggregate approved amount for services or, if less than approved amount, actual aggregate expenditures for services.
Denominator= Aggregate actual expenditures for services.

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

If 'Other' is selected, specify:

MMIS

| Responsible Party for data collection/generation (<i>check each that applies</i>): | Frequency of data collection/generation (<i>check each that applies</i>): | Sampling Approach (<i>check each that applies</i>): |
|---|--|--|
| State Medicaid Agency | Weekly | 100% Review |

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

Data Aggregation and Analysis:

| | |
|---|--|
| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <input type="text"/> | 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 documented findings from SHCN and MHD case reviews which have been remediated. Numerator = Total number of documented findings from SHCN and MHD which have been remediated. Denominator = Total number of documented findings.

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

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|--|--|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

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

If opportunities for improvements are identified, the state will include this information on the CMS-372 report.

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 the attention of MO HealthNet (MHD) through review of the Bureau of Special Health Care Needs (SHCN) reports, as well as through day-to-day activities of the MHD, e.g., review/approval of provider agreements, utilization review and quality review processes, complaints from MHD participants related to waiver participation/operation by phone or letter, etc. MHD addresses individual problems related to delegated functions as they are discovered by contacting DHSS and advising them of the problem. A follow-up memo or email 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 addressed the problem identified by MHD. Written documentation is maintained by both MHD and SHCN and, as needed, discussions will be included at the quarterly meeting. Any trends or patterns will be discussed and resolved as appropriate. Individual problems that are part of the report process will be included in the appropriate reports. The MHD Waiver Review Log will include an analysis of data received from DHSS and data generated by MHD for the purpose of identifying the number and percentage of issues addressed.

ii. Remediation Data Aggregation

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

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

| | |
|--|--|
| Responsible Party (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

c. Timelines

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

No**Yes**

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

Appendix B: Participant Access and Eligibility**B-1: Specification of the Waiver Target Group(s)**

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

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | | | |
|---|----------|---------------------|-------------|--------------------------|--|--------------------------|--|
| | | | | Maximum Age Limit | | No Maximum Age Limit | |
| Aged or Disabled, or Both - General | | | | | | | |
| | | Aged | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| | | Disabled (Physical) | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| | | Disabled (Other) | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| Aged or Disabled, or Both - Specific Recognized Subgroups | | | | | | | |
| | | Brain Injury | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| | | HIV/AIDS | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| | | Medically Fragile | | 21 | | <input type="checkbox"/> | |

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|--|----------|-------------------------------|-------------|-------------------|----------------------|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| | | Technology Dependent | | | |
| Intellectual Disability or Developmental Disability, or Both | | | | | |
| | | Autism | | | |
| | | Developmental Disability | 21 | | |
| | | Intellectual Disability | | | |
| Mental Illness | | | | | |
| | | Mental Illness | | | |
| | | Serious Emotional Disturbance | | | |

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

Individuals who were medically fragile children who had a documented complex medical condition(s) at such a level that their needs could only be met through the skills of a licensed practical nurse or registered nurse for four or more consecutive hours per day prior to the age of 21.

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

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

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

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

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

| Waiver Year | Unduplicated Number of Participants |
|-------------|-------------------------------------|
| Year 1 | 235 |
| Year 2 | 270 |
| Year 3 | 305 |
| Year 4 | 340 |
| Year 5 | 375 |

- 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 | <input type="text"/> |
| Year 2 | <input type="text"/> |
| Year 3 | <input type="text"/> |
| Year 4 | <input type="text"/> |
| Year 5 | <input type="text"/> |

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

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

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

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

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

waiver:

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. **1. State Classification.** The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

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

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

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

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

Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

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

Specify:

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

MO HealthNet for Families-Adult (MHF), 42 CFR 435.110; MO HealthNet for Pregnant Women (MPW), 42 CFR 435.116

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

quarterly), specify the frequency:

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

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

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

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

As specified in the Code of State Regulations (CSR) at 19 CSR 30-81.030 the following criteria are used to evaluate and reevaluate whether an individual meets ICF/IID level of care. The participant must have met the criteria prior to the age of 21:

(1) Behavioral: repeated behavioral challenges that affect their ability to function in the community. (2) Cognition: performance in remembering, making decisions, organizing daily self-care activities, as well as understanding others and making self-understood. (3) Mobility: the ability to move from one place or position to another. (4) Eating: the ability to eat and drink, including the use of special nutritional requirements or a specialized mode of nutrition. (5) Toileting: ability to complete all tasks related to toileting including the actual use of the toilet room (or commode, bedpan, urinal), transferring to on/off the toilet, cleansing self, adjusting clothes, managing catheters, and managing incontinence episodes. (6) Bathing: full body shower or bath. (7) Dressing and Grooming: the ability to dress, and undress, and complete daily grooming tasks. Dressing may also include specialized devices such as prosthetics, orthotics etc. (8) Rehabilitation: physician ordered rehabilitation therapy (speech, occupational, physical), points are based on frequency of services. (9) Treatments: physician ordered medical care or management that requires additional hands on assistance. (10) Medication Management: the ability to safely manage their medication regimen. (11) Meal Preparation: the ability to prepare a meal based on the capacity to complete the task. (12) Safety: identification of a safety risk associated with a visual impairment, unsteady gait, past institutionalization, past hospitalization, and age.

Scoring Methodology: any combination of points which meets the LOC specified in 19 CSR 30-81.030 qualifies an individual to meet LOC. Based on the criteria established in each category, points are assigned in each of the twelve categories in three point increments:

0 points: No conditions reported or observed, no assistance needed only set up or supervision need, no therapies or treatments ordered, no difficulty in vision, falls or recent problems with balance.

3 points: Mental conditions exhibited in the past, requires supervision in decision making, occasional limited or moderate assistance needed, has been institutionalized, therapies ordered less than daily, severe difficulty with vision, fallen and has current problems with balance.

6 points: Mental or behavior conditions and symptoms currently exhibited, requires monitoring by a physician or licensed mental health professional, moderate to maximum assistance needed, therapies ordered daily, treatments needed, no vision, balance issues and fallen in last 90 days.

9 points: Mental conditions and symptoms currently exhibited, requires monitoring by a physician or licensed mental health professional, displays poor decision making and requires total supervision, total dependence on others or maximum assistance needed, therapies ordered more than once per day. Certain criteria are presumed to meet LOC specified in 19 CSR 30-81.030 which may or may not qualify the individual to receive MFAW services: (1) no discernable consciousness, unable to make any decisions (2) total dependence to eat (3) bed-bound (4) age 75 or older with a safety score of six.

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

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

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

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

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

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

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

The Program Manager reviews MOHSAIC, the electronic tracking system, to assure that each participant is assessed every six months. Regional Office staff (Regional Coordinator, Facilitator, and Service Coordinator) track and verify when assessments are coming due to ensure timely reevaluations.

- 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 Bureau of Special Health Care Needs (SHCN) Regional Offices in which the SHCN RN who completes the assessments are domiciled. The Program Manager maintains a copy of the file. The files are stored in locked file cabinets, in a locked room for as long as the participant is receiving waiver services. Upon discharge of the participant the record is microfilmed and maintained indefinitely.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the 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 prior to the receipt of services.

Numerator = Total number of level of care determinations prior to receipt of services.

Denominator = Total number of new waiver enrollees.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review by Program Manager

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

| | | |
|--|--|----------------------|
| | | <input type="text"/> |
| | Other Specify: <input type="text"/> | |

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

Number and percent of level of care determinations completed within six months of

the participant's last LOC evaluation. Numerator = Total number of level of care determinations completed within six months of the last level of care determination.
Denominator = Total number of participant records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|---|--|
| State Medicaid Agency | Weekly | 100% Review |
| Operating Agency | Monthly | Less than 100% Review |
| Sub-State Entity | Quarterly | Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div> |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div> | Annually | Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div> |
| | Continuously and Ongoing | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div> |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div> | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|---|--|
| State Medicaid Agency | Weekly |

| | |
|--|--|
| Responsible Party for data aggregation and analysis (<i>check each that applies</i>): | Frequency of data aggregation and analysis (<i>check each that applies</i>): |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

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

Performance Measures

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

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

Performance Measure:

Number and percent of level of care determinations made by qualified staff.

Numerator = Total number of level of care determinations made by qualified staff.

Denominator = Total number of level of care determinations reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| | | |
|---|--|--|
| Responsible Party for data collection/generation (<i>check each that applies</i>): | Frequency of data collection/generation (<i>check each that applies</i>): | Sampling Approach (<i>check each that applies</i>): |
| State Medicaid Agency | Weekly | 100% Review |
| Operating Agency | Monthly | Less than 100% |

| | | |
|--|--|---|
| | | Review |
| Sub-State Entity | Quarterly | Representative Sample Confidence Interval = <input type="text"/> |
| Other Specify: <input type="text"/> | Annually | Stratified Describe Group: <input type="text"/> |
| | Continuously and Ongoing | Other Specify: <input type="text"/> |
| | Other Specify: <input type="text"/> | |

Data Aggregation and Analysis:

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

| | |
|--|---|
| Responsible Party for data aggregation and analysis (<i>check each that applies</i>): | Frequency of data aggregation and analysis (<i>check each that applies</i>): |
| | |

Performance Measure:

Number and percent of level of care determinations made in accordance with DHSS waiver requirements. Numerator = Total number of level of care determinations made in accordance with DHSS waiver requirements. Denominator = Total number of level of care determinations reviewed.

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

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|--|--|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

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

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 Program Manager reviews all Level of Care Determinations to assure that eligibility is met for initial enrollment and subsequent reevaluations. The Program Manager and/or designee, contact the Bureau of Special Health Care Needs (SHCN) RN by email notification. The email notification identifies the deficiency and states the corrective action needed as well as the date the deficiency was identified, the date staff was notified, and the date of the corrective action was received by the Program Manager. A copy of the correction is required for Central Office records. The Program Manager tracks and trends this data and identifies if system changes are needed to maintain compliance with the waiver. The Program Manager communicates system changes to SHCN staff as needed through regional staff meetings and individual consults by telephone. System changes are reported to the MO HealthNet Division 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 |

| Responsible Party (<i>check each that applies</i>): | Frequency of data aggregation and analysis (<i>check each that applies</i>): |
|--|--|
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

It is the policy of the Department of Health and Senior Services (DHSS) to provide services on a nondiscriminatory basis based on national origin, race, sex, age, disability, color, religion or genetic information. Language barriers may interfere with the provision of services to consumers, leading to misunderstandings and impacting program effectiveness. Effective language services are put in place to help prevent these problems. All 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 DHSS to provide services on a nondiscriminatory basis based on national origin, race, sex, age, disability, color, religion or genetic information.

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

II. POLICY:

It is the intent of DHSS to: establish systems and procedures for the provision of services to any Limited English Proficiency (LEP) individual, particularly those who cannot communicate in spoken or written English;

improve customer relations between DHSS and the people we serve;

assure quality translation and interpretation services by obtaining feedback on the performance of translators and interpreters;

and

provide technical support to all DHSS programs.

III. DEFINITIONS

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

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

TRANSLATION: Written transfer and understanding of a message.

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

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

IV. COMPONENTS:

A. Responsibilities:

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

B. Contracts for Translation or Interpretation:

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

C. Contractors:

1. The contractors shall comply with all applicable provisions of the Civil Rights Act (45 CFR 80), the Rehabilitation Act of 1973 (45 CFR 84), and all other federal and state laws and regulations relating to nondiscrimination. The contractors shall assure

that no person eligible for services shall on the ground of race, color, religion, national origin (this includes individuals of limited English proficiency), sex, disability, veteran status, age or genetic information be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination for any service provided by the contract. The contractors shall, within resources available, ensure minority health issues are addressed in the delivery of services where disparities in health status exist between minority and majority Missourians.

D. Clients of DHSS:

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

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

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Waiver Attendant Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Continued)

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

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

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

This service may not include skilled or nursing care.

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

Service Delivery Method *(check each that applies):***Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by** *(check each that applies):***Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

| Provider Category | Provider Type Title |
|-------------------|-------------------------|
| Agency | Personal Care Providers |

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Waiver Attendant Care****Provider Category:**

Agency

Provider Type:

Personal Care Providers

Provider Qualifications**License** *(specify):*

Certificate *(specify):*

Other Standard (specify):

Personal Care providers are contracted with Missouri Medicaid Audit & Compliance and enrolled with MHD.

Personal Care Providers employ Personal Care Attendants (PCA) who must meet the following qualifications:

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

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

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

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

Missouri Medicaid Audit & Compliance

Frequency of Verification:

Upon initial enrollment and during MMAC Provider Review 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:

Private Duty Nursing

HCBS Taxonomy:**Category 1:**

05 Nursing

Sub-Category 1:

05010 private duty nursing

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

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

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

A maximum of 112 hours per week of Private Duty Nursing may be authorized per participant. Exceptions above the 112 hour per week cap may be authorized on a case by case basis by the Program Manager.

PDN services provided by a family member or legal guardian for a single participant or multiple participants with the same residence may not exceed 12 hours per day up to a maximum of 40 hours per week. A family member or legal guardian shall not be compensated for more than 40 hours of service in a seven-day period. For a family member or legal guardian, 40 hours is the total amount allowed regardless of the number of children who receive 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 |
|-------------------|--------------------------------|
| Agency | Private Duty Nursing providers |

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Private Duty Nursing providers

Provider Qualifications

License (*specify*):

State Home Health Agency 197.400-475RSMo

Certificate (*specify*):

Medicare Home Health Agency

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Missouri Medicaid Audit and Compliance

Frequency of Verification:

Upon initial enrollment and during MMAC Provider Review 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:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications

14032 supplies

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

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

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

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

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

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by (check each that applies):****Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

| Provider Category | Provider Type Title |
|-------------------|-------------------------------------|
| Agency | Durable Medical Equipment companies |

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Supplies****Provider Category:**

Agency

Provider Type:

Durable Medical Equipment companies

Provider Qualifications**License (specify):**

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

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):

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. "Staff" includes anyone employed by the waiver provider and any volunteer that has direct contact with the participants.

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 Medically Fragile Adult Waiver (MFAW) 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 as provided in section 192.2490, RSMo;

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

Employee Disqualification List checks may be submitted directly to the Missouri Department of Health and Senior Services (DHSS).

Providers may satisfy this requirement by conducting an investigation through the Missouri 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 the Missouri Department of Social Services
- 4) The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- 5) The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- 6) Child-Care facility licensing records maintained by the Missouri Department of Health and Senior Services
- 7) Foster parent licensing records maintained by the Missouri Department of Social Services

Providers are also required to make periodic checks of the Employee Disqualification List, maintained by the Missouri Department of Health and Senior Services, to determine whether any current employee, contractor or volunteer has been recently added to the list.

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

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

MFAW providers are required to perform abuse registry screening on all staff employed by the agency. The Missouri Medicaid Audit and Compliance (MMAC) Unit ensure that mandatory investigations have been conducted.

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

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this

registry.

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

The Department of Health and Senior Services (DHSS) is responsible for maintaining the Employee Disqualification List (EDL) and the Family Care Safety Registry (explained in C-2-a). No person is allowed to be employed to work or allowed to volunteer in any capacity in any MFAW program who left or was discharged from employment with any other employer due to abuse or neglect to patients, participants or clients and the dismissal or departure has not been reversed by any tribunal or agency. Each MFAW 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 MFAW provider is also required to make periodic checks of the EDL to determine whether any current employee, contractor or volunteer has been recently added to the list. DHSS produces an annual list in January of each year. Updates are added to the web site each quarter which list all individuals who have been added to or deleted from the EDL during the preceding three months.

Appendix C: Participant Services

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

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

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

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

Appendix C: Participant Services

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

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

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

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

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

Self-directed

Agency-operated

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

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

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.

The relative/legal guardian providing Private Duty Nursing (PDN) must be employed by an enrolled PDN Provider Agency. The PDN Provider agency must provide oversight, supervision and training. All services provided are subject to prior authorization requirements and must be documented by the relative/legal guardian the same as PDN services by any other paid caregiver. Services by a relative/legal guardian are subject to the same program and Missouri Medicaid Audit and Compliance requirements as services by any other paid caregiver.

Other policy.

Specify:

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of waiver providers continuing to meet applicable licensure certification requirements. Numerator = Total number of waiver providers continuing to meet applicable licensure certification requirements. Denominator = Total number of waiver providers enrolled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|--|--|
| State Medicaid Agency | Weekly | 100% Review |
| Operating Agency | Monthly | Less than 100% Review |
| Sub-State Entity | Quarterly | Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div> |
| Other Specify: | Annually | Stratified Describe Group: |

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of new provider applicants with appropriate licensing/certification in accordance with state law and waiver qualifications prior to service. Numerator = Number of provider applicants with appropriate licensing/certification in accordance with state law and waiver qualifications prior to service. Denominator = Number of provider applicants requiring licensing/certification.

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

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance

| Responsible Party for data collection/generation <i>(check each that applies):</i> | Frequency of data collection/generation <i>(check each that applies):</i> | Sampling Approach <i>(check each that applies):</i> |
|---|---|--|
| State Medicaid Agency | Weekly | 100% Review |
| Operating Agency | Monthly | Less than 100% Review |
| Sub-State Entity | Quarterly | Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | Annually | Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
| | Continuously and Ongoing | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|---|--|
| 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): |
| <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |

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

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

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

Performance Measure:

Number and percent of non-licensed/non-certified waiver provider applicants who meet initial waiver provider qualifications. Numerator = Total number of non-licensed/non-certified waiver provider applicants who meet initial waiver provider qualifications. Denominator = Total number of approved non-licensed/non-certified waiver provider applications.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance

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

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

Data Aggregation and Analysis:

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

Performance Measure:**Number and percent of non-licensed/non-certified waiver providers with a valid**

participation agreement with DHSS. Numerator = Total number of non-licensed/non-certified waiver providers with a valid participation agreement with DHSS.
Denominator = Total number of waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance

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

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|---|--|
| State Medicaid Agency | Weekly |

| | |
|---|---|
| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |

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

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

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

Performance Measure:

Number and percent of new waiver providers with staff who have passed designated manager certification. Numerator = Total number new waiver providers with staff who have passed provider designated manager certification. Denominator = Total number new waiver providers that are required to have staff who have passed provider designated manager certification.

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

Data Aggregation and Analysis:

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

| | |
|--|---|
| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
| | <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |

Performance Measure:

Number and percent of providers that have submitted documentation that training requirements for direct care staff were met. Numerator = Total number of providers that have submitted documentation that training requirements for direct care staff were met. Denominator = Total number of providers reviewed that are required to submit training requirements for direct care staff.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance, Provider Contracts Report

| | | |
|---|--|--|
| Responsible Party for data collection/generation <i>(check each that applies):</i> | Frequency of data collection/generation <i>(check each that applies):</i> | Sampling Approach <i>(check each that applies):</i> |
| State Medicaid Agency | Weekly | 100% Review |
| Operating Agency | Monthly | Less than 100% Review |
| Sub-State Entity | Quarterly | Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | Annually | Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
| | Continuously and Ongoing | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
| | Other Specify: | |

| | | |
|--|--|--|
| | | |
|--|--|--|

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|---|---|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. Remediation Data Aggregation

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

| Responsible Party <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|--|--|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

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

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

The Medically Fragile Adult Waiver 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, or 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.

The MO HealthNet Division (MHD) has found that the Medically Fragile Adult Waiver (MFAW) settings are compliant with the Home and Community-Based Services (HCBS) Final Rule Settings criteria. Below are reasons why MHD has come to that conclusion.

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

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

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.

The Bureau of Special Health Care Needs staff validate that settings remain in compliance during quarterly home visits and during monthly contacts 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:

Plan of Care

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

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

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

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

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)**b. Service Plan Development Safeguards.** *Select one:*

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A Plan of Care shall be developed from the information obtained during the assessment process. This plan is a guideline for how services shall be provided to meet the needs of the participant and/or responsible party. Requirements for plan development include a time line for completion, notice and arrangements for meeting to develop the plan, and team members to be included.

The participant and/or responsible party chooses whom he/she would like to participate as a member of the service plan development team.

The Plan of Care shall be developed in cooperation with the participant and/or responsible party identifies the following:

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

2. Client Assessment of medical needs.

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

3. Review of medical records/documentation.

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

4. An Emergency Preparedness Plan is discussed.

Emergency preparedness materials are discussed with the participant and/or responsible party and assistance 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. MFAW 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. The SHCN RN reviews the plan with the participants and/or responsible parties to ensure the safety of the participants on an ongoing basis.

5. Backup caregivers and plan are identified and documented.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A list of qualified providers is available to participants through the Bureau of Special Health Care Needs (SHCN) RN. SHCN has access to MO HealthNet (MHD) Information System with enrolled provider information. Each SHCN Regional Office 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/responsible party at the initial assessment home visit, and as requested. A list of qualified providers is also available through the MHD website <http://dss.mo.gov/mhd/index.htm>. Participants and/or responsible party are asked to choose their service provider and the Client Choice Statement is completed.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Each Plan of Care is reviewed by the Program Manager and is available to the MO Healthnet Division (MHD). A random sample of 25 participants is reviewed annually by MHD. This review ensures participants receiving waived services have a Plan of Care in effect for the period of time services are provided, and that services are provided in accordance with the Plan of Care.

The operating agency, the Department of Health and Senior Services (DHSS), annually reviews 100% of records. MHD reviews the results of the DHSS review including corrective actions and determines if any additional action is needed. As an added layer of oversight, MHD performs the separate review of 25 randomly-selected participants, (referred to in previous paragraph) in addition to the 100% reviewed by DHSS.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

Medicaid agency

Operating agency

Case manager

Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

a. Monitoring and implementation of the Plan of Care and participant health and welfare is the responsibility of the Bureau of Special Health Care Needs (SHCN) RN and the provider agency. The provider agency monitors the provision of services by their RN/LPN to ensure provision of services in accordance with the approved Plan of Care and communicates with the participant's healthcare provider and/or the SHCN RN and/or Regional Coordinator as necessary.

b-c. The Plan of Care and provision of services are monitored through monthly contacts by SHCN 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 form annually, which includes information on how to initiate the process to appeal decisions about services authorized. An in-home visit is performed every three months with a review of the Plan of Care. The plan is revised/updated every six months or as needed, and rewritten annually.

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

Participants have access to waiver services identified in the Plan of Care by documenting referrals made, accepted and attempts to secure difficult-to-obtain services.

Services meet the needs of the participant by documentation of stability of health (lack of hospitalizations, updates from doctor's visits, and participant/responsible party/provider report) and reported participant satisfaction. Satisfaction surveys are conducted annually alternating survey audience each year. Participant and family surveys are completed each odd year and provider surveys are completed each even year. Participant satisfaction is collected annually as part of the Service Coordination Assessment, in addition to the participant satisfaction surveys conducted each odd year.

Back-up plans are effective by evidence that care was safely and adequately provided as reported by the participant and/or responsible party in the absence of the provider agency.

Participant health and welfare is assured by evidence that the participant is stable and there have been no reports of abuse/neglect or exploitation made by participant, responsible party, or provider.

Participants and/or responsible party exercise free choice of providers. The Client Choice Statement is explained and discussed annually with the participant and/or responsible party. A list of qualified providers is available as needed or requested by the participant and/or responsible party or to explore other provider options.

Participants have access to non-waiver services. When needs are identified that are not funded by the waiver, appropriate referrals are made. For example, a referral may be made to local agencies that provide funding for various needs such as building a ramp, home repairs, non-medical transportation, etc.

Services are furnished in accordance with the Plan of Care by reviewing nursing notes and the monthly monitoring log that is required to be submitted by the provider agency. The log lists services authorized and delivered, and requires a reason for services not delivered in accordance with the plan.

The Program Manager reviews and approves 100% of all participants Plan's of Care.

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

The MO HealthNet Division (MHD) annually reviews a sample of participant records. Participant records are reviewed for compliance with applicable federal laws pertaining to Plan of Care, Level of Care, Client Choice Statement, as well as health and welfare requirements. Annual reports are tracked and trended to identify any problems and determine needed remediation which are addressed in 90 days. SHCN provides follow-up MHD on the findings and puts policy and or procedures in place as needed for remediation.

b. Monitoring Safeguards. *Select one:*

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

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the 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 with assessed needs, including health and safety risk factors, and personal goals, identified and addressed. Numerator = Total number of service plans with assessed needs, including health and safety risk factors, and personal goals, identified and addressed. 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 = <input type="text"/> |
| Other Specify: <input type="text"/> | Annually | Stratified Describe Group: <input type="text"/> |
| | Continuously and Ongoing | Other Specify: <input type="text"/> |
| | Other Specify: <input type="text"/> | |

Data Aggregation and Analysis:

| | |
|--|---|
| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <input type="text"/> | 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): |
| | <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |

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

Performance Measures

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

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

Performance Measure:

Number and percent of service plans developed in accordance with waiver requirements and DHSS policy and procedure. Numerator = Total number of service plans developed in accordance with waiver requirements and DHSS policy and procedure. 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 = <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
| Other Specify: | Annually | Stratified Describe Group: |

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

Data Aggregation and Analysis:

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

- 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 reviewed and 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 = <input type="text"/> |
| Other Specify: <input type="text"/> | Annually | Stratified Describe Group: <input type="text"/> |
| | Continuously and Ongoing | Other Specify: <input type="text"/> |
| | Other Specify: <input type="text"/> | |

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|--|---|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div></div> |

Performance Measure:

Number and percent of service plans that were reviewed and revised, as warranted, on or before waiver participant's annual review date. Numerator = Total number of service plans that were reviewed and revised as warranted, on or before waiver participant's annual review. 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 = <div></div> |
| Other | Annually | Stratified |

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

Data Aggregation and Analysis:

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

- 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 = <input type="text"/> |
| Other Specify: <input type="text"/> | Annually | Stratified Describe Group: <input type="text"/> |
| | Continuously and Ongoing | Other Specify: <input type="text"/> |
| | Other Specify: <input type="text"/> | |

Data Aggregation and Analysis:

| | |
|---|---|
| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |

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 waiver participant records with appropriately completed and signed Client Choice statement that specifies choice offered between institutional care and waiver services. Numerator = Total number of waiver participant records with appropriately completed and signed Client Choice statement. Denominator = Total number of records reviewed.

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

If 'Other' is selected, specify:

| | | |
|---|--|--|
| Responsible Party for data collection/generation <i>(check each that applies):</i> | Frequency of data collection/generation <i>(check each that applies):</i> | Sampling Approach <i>(check each that applies):</i> |
|---|--|--|

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

Data Aggregation and Analysis:

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

| | |
|--|--|
| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |

Performance Measure:

Number and percentage of service plans reviewed that indicate the participant/responsible party was offered a choice of service providers. Numerator = Total number of service plans reviewed that indicate participant/responsible party was offered a choice of service providers. 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 <i>(check each that applies):</i> | Frequency of data collection/generation <i>(check each that applies):</i> | Sampling Approach <i>(check each that applies):</i> |
| State Medicaid Agency | Weekly | 100% Review |
| Operating Agency | Monthly | Less than 100% Review |
| Sub-State Entity | Quarterly | Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> | Annually | Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |
| | Continuously and Ongoing | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> |
| | Other | |

| | | |
|--|-------------------------|--|
| | Specify: <div></div> | |
|--|-------------------------|--|

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|--|---|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div></div> |

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

While the current process meets the federal quality reporting requirements, the MO HealthNet Division and the Department of Health and Senior Services will continue to research methods to enhance reporting capabilities. Once improvements are identified, the state will include this information on the CMS-372 report.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the 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.

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

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

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

ii. Remediation Data Aggregation

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

| Responsible Party(<i>check each that applies</i>): | Frequency of data aggregation and analysis (<i>check each that applies</i>): |
|--|---|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div></div> |

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

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

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

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

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

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

During the assessment process, the Bureau of Special Health Care Needs (SHCN) RN provides each participant with a Client Choice Statement and a list of qualified providers. The participant and/or responsible party's choice of a qualified provider is documented. The Client Choice Statement includes the following information regarding appeal rights:

"I understand if my services are reduced, closed or denied, I will be advised in writing. I will have the right to appeal the decision as specified in 42 Code of Federal Regulations 431.200-250. A hearing may be requested within 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 10 days of the date of the letter, the services will continue pending the hearing decision. I understand if the decision is made to proceed with the reduction, termination or denial of services, the State has the right to take back the payment of any services that were asked to be continued."

The address and phone number for MHD Participant Services is provided in the letter.

When services are reduced, terminated or denied, the participant is given written notification by the SHCN RN that includes their appeal rights, process to request a hearing and the process for maintaining services. Notices of adverse actions and the opportunity to request a fair hearing are retained in the participant's case records maintained by SHCN.

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

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution

process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

No. This Appendix does not apply

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

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

Critical incidents include abuse (physical, sexual, or emotional; exploitation; and misappropriation of funds/property) and neglect (inflicted by self or others). Missouri statutes include a universal mandated reporting, stating that any person having reasonable cause to suspect that an eligible adult is experiencing abuse or neglect and in need of protective services shall report such information to the Department of Health and Senior Services (DHSS). This universal mandate has no statutory penalties for not reporting and contains no immunity for those who do report. Missouri statutes (192.2410, RSMo) also include specific language in certain sections that mandate various entities to report possible abuse and/or neglect or cause a report of possible abuse and/or neglect to be made to DHSS. The entities that are mandated to report are: adult day care worker; chiropractor; Christian Science practitioner; coroner; dentist; embalmer; employee of the Departments of Social Services, Mental Health, or Health and Senior Services; employee of a local area agency on aging or an organized area agency on aging program; funeral director; home health agency or home health agency employee; hospital and clinic personnel engaged in examination, care, or treatment of persons; in-home services owner, provider, operator, or employee; law enforcement officer; long-term care facility administrator or employee; medical examiner; medical resident or intern; mental health professional; minister; nurse; nurse practitioner; optometrist; other health practitioner; peace officer; pharmacist; physical therapist; physician; physician's assistant; podiatrist; probation or parole officer; psychologist; consumer-directed services provider (this covers IL Waiver providers); personal care attendant; or social worker. When any of these entities has reasonable cause to believe that a participant has been abused or neglected are to IMMEDIATELY after being made aware of such critical incidents, report or cause a report to be made to the department. These mandated reporters who fail to report or cause a report to be made to DHSS within a reasonable time after the act of abuse or neglect is guilty of a Class A misdemeanor. (198.070 and 192.2475, RSMo) The methods of reporting include calling DHSS staff or the Central Registry Unit 800# (this number is promoted on DHSS public information, brochure, posters and website), written correspondence with DHSS or through the 'Ask Us' function on DHSS' website. Reports are typically logged through the Central Registry Unit, as it is often the first point of contact for the public. However, reports are also logged at field offices when calls are taken directly at those locations.

Central Registry staff determine the report is for an eligible adults, determines priority level, and whether or not there is adequate information to meet reporting criteria. If the report meets reporting standards the report is immediately sent to the field workers through the DSDS computer system. If the report does not meet reporting criteria the report is documented, but not sent to the field workers.

Protective Services Unit Reports – Class I reports must be initiated within one hour of being reported with a face-to-face visit as soon as possible within 24 hours. Class II reports must be initiated within 48 hours of being reported with a face-to-face visit as soon as possible within seven calendar days. Class III reports do not require a face-to-face visit, however the reporter must be contacted within 7 calendar days to collect additional information. Investigative Reports and Employee Disqualification List reports must be initiated as soon as possible but no more than 5 days of being reported.

Special Investigations Unit Reports – Physical Abuse, Sexual Abuse, Caregiver Neglect Medical, Caregiver Neglect Non-Medical Reports – The eligible adult must be contact within 30 calendar days and the alleged perpetrator must be contacted within 45 calendar days of being reported. Misappropriation: The eligible adult shall be contacted as soon as possible but no more than 7 calendar days from the SIU report and the alleged perpetrator must be contacted within 45 calendar days of being reported. Falsification: The eligible adult shall be contacted as soon as possible but no more than 45 calendar days from the SIU report and the alleged perpetrator must be contacted within 45 calendar days of being reported.

All reports must be documented and closed on or before the 60th calendar day from initial report unless an exception is requested.

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 form upon initial assessment and quarterly and annually, by the Bureau of Special Health Care Needs (SHCN) RN. This document includes definitions of Abuse Neglect and/or Exploitation (ANE) and examples to assist the SHCN RN to teach the participant and/or responsible party to identify ANE, the use of inappropriate restraints, seclusion or restrictive interventions. Contact information for the SHCN RN and the following statement is included: "If you feel your rights have been violated or if you or your family have been abused, neglected, or exploited, contact: Elder Abuse or Neglect Hotline 1-800-392-0120."

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

The Department of Health and Senior Services (DHSS) is the mandated adult protective services agency in Missouri. Statute 192.2415 RSMo defines the investigatory authority of DHSS as limited to eligible adults with a protective service need. DHSS Division of Senior and Disability Services (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 to be registered into the Mo Case Compass and Aspen Complaints/Incidents Tracking System (ACTS) data base system.

The following is applicable to waiver participants receiving services in their own home:

Preliminary classification of reports is based on information received from the reporter at the point of intake.

Classification is based on the level of harm or risk to the reported adult, combined with the reported need to gather evidence. Class I reports contain allegations, which if true, present either an imminent danger to the health, safety or welfare of an eligible adult or a substantial probability that death or serious physical harm will result. Class I reports involve situations of a crisis or acute nature which are currently occurring and require immediate intervention and/or investigation to gather critical evidence. (Reporters are directed to contact the local law enforcement agency on reports involving allegations of homicide or suicidal threats). Class II reports contain allegations of some form of abuse, neglect, or exploitation of an eligible adult but do not allege or imply a substantial probability of immediate harm or danger. Situations described in a Class II report do not require an immediate response. DHSS staff are responsible for the investigative process. Mo CaseCompass develops a baseline investigation plan which includes a standard set of Activities/Tasks for an investigation. The investigator can add additional activities/task as needed. The investigative plan is completed inside the MO CaseCompass system providing notifications and alerts to the investigator of required policy tasks and completion of investigation. 1) Review of the report and conducting background checks of the subjects of the report. 2) Development of an investigative plan, outlining the actions to be taken in accordance with the reported information. The investigative plan will include the assessed need to involve medical professionals; the order of the interviews to be conducted, i.e., reporter, reported adult, witnesses and the alleged perpetrator; determination of which records or documents need to be obtained to (dis)prove the allegations in the report; evidence suggested in the report to be immediately obtainable which will assist in (dis)proving the allegations and determination of which agency or entity (if any) that needs to be contacted to co-investigate or provide support. 3) A thorough investigation is conducted obtaining all information necessary to determine whether the alleged abuse, neglect or exploitation actually occurred (or is occurring). The information is gathered and memorialized through documentation to properly preserve the evidence. 4) Evaluation, analysis, organizing and reviewing the information to determine if legal intervention or protective services is warranted. This shall include further follow-up and resolution when there are discrepancies or inconsistencies, evaluating the risk of harm or injury to the reported adult and assessing the capacity of the reported adult and providing necessary interventions. 5) Completion of a summary and determining the investigative conclusion according to the information obtained during the investigation. This will include recording all contacts and activities related to the investigation in the case record. It will also include submitting a copy of the investigation and findings to the Division's Community Health Nurse Consultant if involves deteriorating health condition, local police, local prosecutor or DHSS Office of General Counsel when the information gathered substantiates the allegation. A copy of the report is also sent to the DHSS Employee Disqualification List staff when a referral to this list warrants consideration. 6) Policy requires that investigations are conducted and completed and findings/results entered into the Mo CaseCompass system within a 90 day period. In response to Class I reports, a face-to-face must be made as soon as necessary or possible within the 24 hours following receipt of a report to ensure the safety and well-being of a reported adult. The 24-hour period will begin at the time the information was received by DSDS. Investigations of Class II reports shall be initiated within a period not to exceed 48 hours after receipt of the report or by close of business the first working day after a weekend or holiday. Investigators shall conduct a face-to-face interview as soon as possible within a period not to exceed 7 calendar days from the receipt of the report. A waiver participant for whom an investigation is being conducted is involved in the investigation and the subsequent intervention process or plan on an ongoing basis. State statutes specifically, 192.2435, 192.2500 and 192.2505 RSMo prohibit DHSS from disclosing the investigative results/reports to anyone other than the participant/legal representative upon request, the Attorney General's office to perform that office's constitutional or statutory duties, the Department of Mental Health for residents placed through that Department to perform its constitutional or statutory duties, the appropriate law enforcement agency to perform its constitutional or statutory duties, or the Department of Social Services for individuals who receive MHD benefits to perform its constitutional or statutory duties.

The Program Manager reviews all Event Reports and provides consultation to the SHCN staff regarding reporting and follow-up documentation. Events are reported to the Program Manager immediately upon notification that ANE has occurred or been alleged. SHCN staff documents details on the Event Report and sends to the Program Manager. Bureau of Special Health Care Needs (SHCN) staff calls the Hotline to also inform them that SHCN is providing services to the participant and is available to the Central Registry Unit (CRU) if needed, during the investigation. SHCN staff requests that the Division of Senior and Disability Services (DSDS) staff notify SHCN if the investigation of the event was/was not completed within the appropriate timeframe, if the investigation was closed within 60 days (per DSDS Policy) and if substantiated what actions were taken to ensure the safety of the participant. The Program Manager maintains an Event Log and determines the number and percent of waiver participants who have had an Event Report that resulted in an investigation that was initiated within the Class I or Class II Investigation timeframe, divided by the number of records reviewed. SHCN staff review individual problems that have occurred during the last face-to-face contact through monthly contacts to identify if there has been a resolution of the problem. Subsequent Event Reports may be completed for problems not resolved, with additional contact to the CRU.

Participants/families/representatives requesting results of investigations receive a letter within three days of their request. The letter states that their request has been received and records will be provided in approximately 45 days.

The Program Manager reviews all Death Notification forms and provides consultation to the SHCN staff regarding follow-up documentation. Participant deaths are reported by SHCN 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 SHCN was notified and other comments. The Program Manager maintains a mortality log. If there is a police investigation of the participant's death, the outcome of the investigation is added to the Death Notification form and the mortality log is updated with the results of the investigation.

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

The Department of Senior Services (DHSS), Division of Senior and Disability Services (DSDS), is responsible for overseeing the operation of the incident management system. DSDS supervisors are required to read 100% of all third party perpetrator reports and 100% of all class I reports regarding imminent harm as well as periodic reviews of all other reports. (This applies to waiver participants receiving services in their own home.) Supervisor reviews are triggered based on criteria in the MO CaseCompass system. This supervisory review determines if the staff person conducting the investigation has followed policy and procedure during the investigation, has communicated with all the necessary parties, and has documented the investigation correctly. This oversight is conducted on an 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 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 ANE are used to prevent reoccurrence through education and changes in policy and procedures including but not limited to staff provider training and public awareness. DSDS provides summary reports to the Medicaid Agency no less than annually.

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of restraints

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

Bureau of Special Health Care Needs (SHCN) staff reviews documentation in the participant's file, specifically reviewing for unauthorized restraint and seclusion. Inappropriate use of restraints or seclusion, frequent hospitalizations or emergency care, or injuries of unknown origin will be reported to the DHSS Abuse and Neglect hotline if ANE is suspected, as identified during monthly contacts and home visits. SHCN receives notification from DSDS if a hotline is reported to be for a MFAW participant.

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

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

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

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

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of restrictive interventions

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

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

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

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

are available to CMS upon request through the Medicaid agency or the operating agency.

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

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of seclusion

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

b. Medication Management and Follow-Up

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

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

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

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

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

Complete the following three items:

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the 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 instances of abuse, neglect, exploitation and unexplained death.* (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

Number and percent records reviewed where participant/family/legal guardian rcvd info/education on reporting abuse, neglect, exploitation and other critical incidents as specified in waiver. Numerator=Number of records reviewed where participant/family/legal guardian rcvd info/education on reporting abuse, neglect, exploitation 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 = <input type="text"/> |
| Other Specify: <input type="text"/> | Annually | Stratified Describe Group: <input type="text"/> |
| | Continuously and Ongoing | Other Specify: <input type="text"/> |
| | Other Specify: <input type="text"/> | |

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of service plans with an adequate backup plan specified in their service plan. Numerator = Total number of service plans with an adequate backup plan specified. 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 <i>(check each that applies):</i> | Frequency of data collection/generation <i>(check each that applies):</i> | Sampling Approach <i>(check each that applies):</i> |
|---|--|---|
| State Medicaid Agency | Weekly | 100% Review |
| Operating Agency | Monthly | Less than 100% Review |
| Sub-State Entity | Quarterly | Representative Sample Confidence Interval = <input type="text"/> |
| Other | Annually | Stratified |

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of records reviewed where the participant/responsible party was provided information on who to contact regarding complaints. Numerator = Total number of records reviewed where participant/responsible party was provided information on who to contact regarding complaints. Denominator = Total number of participant records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|---|--|
| State Medicaid Agency | Weekly | 100% Review |
| Operating Agency | Monthly | Less than 100% Review |
| Sub-State Entity | Quarterly | Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | Annually | Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
| | Continuously and Ongoing | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | |

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|---|--|
| State Medicaid Agency | Weekly |

| | |
|---|---|
| Responsible Party for data aggregation and analysis <i>(check each that applies):</i> | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div> |

Performance Measure:

Number and percent of Event Reports that resulted in an investigation that was initiated within required timeframes. Numerator = Number of Event Reports that resulted in an investigation initiated within required timeframes. Denominator = Number of Event Report investigations reviewed.

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

If 'Other' is selected, specify:

| | | |
|---|--|--|
| Responsible Party for data collection/generation <i>(check each that applies):</i> | Frequency of data collection/generation <i>(check each that applies):</i> | Sampling Approach <i>(check each that applies):</i> |
| State Medicaid Agency | Weekly | 100% Review |
| Operating Agency | Monthly | Less than 100% Review |
| Sub-State Entity | Quarterly | Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div> |
| Other Specify: | Annually | Stratified Describe Group: |

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

| | |
|---|---|
| Responsible Party for data aggregation and analysis (<i>check each that applies</i>): | Frequency of data aggregation and analysis (<i>check each that applies</i>): |
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

| | | |
|---|--|--|
| Responsible Party for data collection/generation (<i>check each that applies</i>): | Frequency of data collection/generation (<i>check each that applies</i>): | Sampling Approach (<i>check each that applies</i>): |
| State Medicaid | Weekly | 100% Review |

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

Data Aggregation and Analysis:

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

| Responsible Party for data aggregation and analysis (<i>check each that applies</i>): | Frequency of data aggregation and analysis(<i>check each that applies</i>): |
|---|---|
| | Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The Program Manager reviews all Event Reports and provides consultation to the SHCN staff regarding reporting and follow-up documentation. Events are reported to the Program Manager immediately upon notification that ANE has occurred or been alleged. SHCN staff documents details on the Event Report and sends to the Programs Manager. SHCN staff calls the Hotline to also inform them that SHCN is providing services to the participant and is available to the CRU if needed, during the investigation. SHCN staff requests that the DSDS staff notify SHCN if the investigation of the event was/was not completed within the appropriate timeframe, if the investigation was closed within 60 days (per DSDS Policy), and if substantiated what action were taken to ensure the safety of the participant. The Program Manager maintains an Event Log and determines the number and percent of waiver participants who have had an Event Report that resulted in an investigation that was initiated within the Class I or Class II Investigation timeframe, divided by the number of records reviewed. SHCN staff review individual problems that have occurred during the last face-to-face contact through monthly contact to identify if there has been a resolution of the problem; Subsequent Event Reports may be completed for problems not resolved, with additional contact to the CRU.

ii. Remediation Data Aggregation

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

| Responsible Party(<i>check each that applies</i>): | Frequency of data aggregation and analysis(<i>check each that applies</i>): |
|--|---|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: | Annually |

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

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and

- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

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

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

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

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

No less than annually, MO HealthNet Division (MHD) Program Operation Staff and Department of Health and Senior Services (DHSS)/Bureau of Special Health Care Needs (SHCN) Program staff meet to discuss the Quality Improvement Strategy (QIS) described throughout the Medically Fragile Adult Waiver—40190; Brain Injury Waiver-1406; AIDS Waiver—0197; Aged & Disabled Waiver—0026; Independent Living Waiver—0346; Adult Day Care Waiver—1021.

At this time, DHSS Program Oversight staff and MHD Program Operations staff jointly review the performance measures and analyze corresponding reports generated by both agencies. MHD and DHSS review the outcome of the reports to ensure they are meeting the assurances specified throughout the application and what, if any, action may be necessary for remediation and or system improvement.

Systemic errors and trends are identified by MHD and DHSS based on the reports for each performance measure using the number and percent of compliance.

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

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

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

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

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

All reports are stratified by waiver.

ii. System Improvement Activities

| Responsible Party <i>(check each that applies):</i> | Frequency of Monitoring and Analysis <i>(check each that applies):</i> |
|--|---|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Quality Improvement Committee | Annually |
| Other Specify: <input type="text"/> | Other Specify: <input type="text"/> |

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 Quality Improvement Strategy meeting based on new reports on the established performance measures. Significant systemic issues will be addressed by the MO HealthNet Division and/or Department of Health and Senior Services through increased reporting or monitoring as deemed necessary and appropriate.

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

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

Appendix 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*):

A state agency developed satisfaction survey is utilized. The survey is administered to all Medically Fragile Adult Waiver (MFAW) participants/families and was specifically developed to determine the needs of participants enrolled in the MFAW.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

Providers of Home and Community-Based Services (HCBS) are required to maintain financial records and service documentation on each waiver participant, including name of participant, participant's MO HealthNet identification number, name of individual(s) who delivered the service, date service was rendered, and units of service provided. Services provided through the waiver must be prior authorized by the Department of Health and Senior Services (DHSS) staff. Prior Authorizations (PAs) are based on agreed-upon services established during the service planning process. Authorized services are forwarded to Department of Social Services, MO HealthNet Division's (MHD) fiscal agent via an electronic system. Providers bill claims to and subsequently receive payment directly from MHD as reimbursement. MHD makes a Remittance Advice indicating the disposition of billed claims available to providers.

Providers are not required to have independent audits performed.

The Missouri Medicaid Audit and Compliance Unit (MMAC) within the Department of Social Services (DSS) conducts periodic compliance audits in which documentation of services provided is reviewed to ensure services billed to MHD were provided and documented as required per State regulation. Selection of participants may be determined based on a focus area of concern, a random sample, or a 100% review of each participant. It is MMAC's intent to review all HCBS providers on a rotating basis, every 3-5 years. In addition to the aforementioned audits, specific or focus audits may be completed due to providers with a history of problematic billing or complaints. Follow up audits to a regular or focus review audit may be completed to determine if a provider has addressed previous issues and/or made appropriate changes. The audit time period may range from 3-6 months but may be expanded based on the results of the audit and the egregiousness of the findings. The audit may be a random sample or hundred percent claim review.

Claims submitted by the provider are subjected to edits in the billing system, MMIS to ensure that payment is made only on behalf of those consumers who are MO HealthNet eligible and to providers who are enrolled on the date a service is delivered. The provider subsequently receives payment directly from MO HealthNet as reimbursement. MO HealthNet makes a Remittance Advice indicating the disposition of billed claims available to the provider.

Statistically valid samples are generally not used to determine which providers are reviewed. Should a current HCBS provider also be an Medically Fragile Adult Waiver (MFAW) provider, the review of the MFAW provider would occur at that time; therefore, approximately 100% of MFAW providers will be reviewed at least every 3-5 years. Utilization reports and trends are monitored between audits.

Each year, MMAC prepares a work plan for areas of focus and selection of providers for review. Input includes Office of Inspector General (OIG) work-plan; Centers for Medicare and Medicaid Services (CMS) guidance; complaints/referrals/hotlines from the public, participants, other providers, other agencies such as licensing boards, Departments of Health and Senior Services (DHSS), Mental Health (DMH), contractors, 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. It is MMAC's intent to review all HCBS providers on a rotating basis, every 3-5 years. During the preparation of the work plan each year, an active provider list is compared against MFAW providers who have been audited in the last 3 years. From the list of providers who have not been audited, a list of potential providers to audit is created. In addition, if a current HCBS provider is also an MFAW provider, the review of the MFAW provider would occur at that time; utilization reports, dashboards and trends are also monitored to determine if an audit should occur. Therefore, approximately 100% of MFAW providers will be reviewed at least every 3-5 years.

Reviews may be performed on-site or as a desk audit. A desk audit may be considered for small providers with few participants in an outlying 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. Providers may then mail, fax, or e-mail records in a HIPAA secure manner. Other than the records being sent in by the provider, the desk audit process is the same as on-site audits. The same in-depth review of records is completed and the same types and numbers of records are collected. Providers may 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 to be included in the audit.

Whether MMAC conducts a desk review or an on-site audit, auditors collect or receive documents from providers that are compared to provider billing and participant care plans. MMAC will determine if services were authorized and properly documented, and if billing is appropriate. Providers have the responsibility of ensuring they have documentation to support services provided prior to the filing of claims. The State requires providers to retain documentation for five years, but generally utilizes a three year look-back period due to availability of billing records.

Documentation that supports provider billing is reviewed. Verification of correct names, and the in and out times, etc., are also reviewed. MMAC expects to see any and all other documentation to support the provider's billing, such as time sheets, physician's orders, nurse visit reports, etc. MMAC will contact participants to determine if they received services if a question exists regarding actual provision of services.

Participants' current plans of care and progress notes are reviewed to verify the plan is being followed and notes are being maintained. MMAC personnel may access participant care plans through the HCBS Web Tool database. MMAC expects providers to have access through the HCBS Web Tool or paper copies of participants' care plans and to have documentation of employee registration and screening (and application and granting of a good cause waiver (GCW), if necessary).

During an audit, MMAC checks every employee who has contact with any participant who is part of the audit. MMAC will sample training and orientation documents during an audit; the number is dependent upon the number of employees. MMAC personnel are independently able to verify employees' registration and screening through the Family Care Safety Registry (FCSR). MMAC reviews for licensure qualifications, age qualifications, training and orientation qualifications, and other program specific qualifications.

Background screening is reviewed as part of MMAC's audit. HCBS providers are required to do criminal background checks on employees, as some employees, including direct care workers, are required to be registered with DHSS, FCSR. Providers use the FCSR to perform background checks. MMAC ensures employees are properly registered or have properly disclosed, that initial and periodic screenings are performed, and Good Cause Waivers (GCW) are applied for and received as necessary. State Statutes require regulated health care employers to obtain background screenings prior to hiring an employee, to include the FCSR. Individuals with certain type of criminal history findings identified in their background screening cannot be hired. Individuals who have been determined to have abused or neglected a resident, patient, client, or consumer; misappropriated funds or property belonging to a resident, patient, client, or consumer; falsified documentation verifying delivery of services to an in-home services client or consumer; or who have been found guilty of a Class A and B felony e.g., crimes against a person, robbery, child abuse, etc., are disqualified from being employed. All background screenings occur prior to hiring an employee.

As necessary, employees can request a GCW from DHSS' Division of Regulation and Licensure (DRL). 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. Upon submission of the GCW application to the DRL, each case is reviewed by a panel for approval or denial. Each case is unique and may require additional information from the applicant, and there is no set time when a GCW is determined. Although this list is not exhaustive of the information taken in regard to the GCW application, the panel looks at: age of the applicant when the finding(s) occurred; circumstances surrounding incident(s); length of time since the incident(s) occurred to the time of the GCW request; applicant's work history; and any other information relevant to applicant's employment background or past actions indicating whether they would pose a risk to the health, safety or welfare of residents, patients or clients, etc. An individual who has been placed on the DHSS' Employee Disqualification List (EDL) is not eligible to receive a GCW. Verification of screening is requested and reviewed to see if employees have been screened and if screenings were done timely.

MMAC reviews its State Regulations pertaining to sanctions (13 CSR 70-3.030) to determine appropriate sanctions for providers found to have violations as a result of an MMAC audit. Sanctions may include improperly paid money being recouped; or the provider may face more serious sanctions such as suspension or termination. Providers may face less serious sanctions in situations where money was properly paid (there was no adverse finding rendering the employee unqualified but the provider failed to timely screen the employee, for instance).

Once the audit has been finalized, the provider will receive a letter outlining findings, violations and sanctions. The provider has 30 days to appeal and 10 days to submit a plan of correction. In the event of an overpayment, providers have 45 days to work with MMAC to set up a repayment plan. Providers may receive letters that include overpayments with sanctions or an education letter with findings that will require a plan of correction. If the provider is found to not have violations, the provider will receive a "No Findings Letter" stating they did not have violations.

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

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

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

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver claims paid for services that are included in the approved

waiver. Numerator = Total number of waiver claims paid for services that are included in the approved waiver. Denominator = Total number of waiver claims paid.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

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

Data Aggregation and Analysis:

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|---|--|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|---|---|
| Sub-State Entity | Quarterly |
| Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Financial records (including expenditures)

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 |

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

Data Aggregation and Analysis:

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

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

| |
|--|
| |
|--|

b. Methods for Remediation/Fixing Individual Problems

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

State financial oversight exists to assure claims are coded and paid in accordance with the reimbursement methodology in the approved waiver. Claims payment issues are the responsibility of the MO HealthNet Division (MHD). MHD works to resolve payment issues as they are identified by MHD and or the Department of Health and Senior Services (DHSS). Remediation occurs through changes in policy, procedure or Medicaid Management Information Systems (MMIS) system edits or audits.

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

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

ii. Remediation Data Aggregation

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

| Responsible Party (check each that applies): | Frequency of data aggregation and analysis (check each that applies): |
|---|---|
| State Medicaid Agency | Weekly |
| Operating Agency | Monthly |
| Sub-State Entity | Quarterly |
| Other Specify: <div></div> | Annually |
| | Continuously and Ongoing |
| | Other Specify: <div></div> |

c. Timelines

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

No

Yes

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

Appendix I: Financial Accountability

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

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

The reimbursement rates for Waiver Attendant Care and Private Duty Nursing services are based on similar State Plan offerings. The reimbursement rates for these services are subject to and 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 Home Care provider industry and participants to develop rate changes during the annual appropriations process and development of the State budget.

The year current rates were set for all services in the waiver is 2019.

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

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

Rates for waiver services are historically based on four factors. These four factors are the Missouri hourly minimum wage, gas prices for the Midwest per gallon, the hourly amount for Medically Fragile Adult Waiver 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 legislature makes the decision regarding any updates at this time.

The rates established by the MO 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>. The rates for specialized medical supplies are based on the MHD reimbursement rate for Durable Medical Equipment which is wholesale cost plus 20% for shipping and handling. 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 the Department of Health and Senior Services (DHSS), by e-mail to ASK MHD, or by phone call to the MHD Participant Services Unit.

It is not the standard practice for the Bureau of Special Health Care Needs (SHCN) to provide the rates/costs of services to all waiver participants and/or responsible parties, however, SHCN does provide the rates/costs of services to the participant and/or responsible party upon request.

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

All services provided under this Waiver Program are prior authorized by the Bureau of Special Health Care Needs (SHCN) RNs, subject to approval by the MO HealthNet Division (MHD). The prior authorization is forwarded to the MHD Fiscal Agent. Providers of services bill claims for services directly to the MO HealthNet Fiscal Agent for claims processing. All claims are processed through the Medicaid Management Information System. 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:

The Bureau of Special Health Care Needs (SHCN) staff determine 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 Medicaid Management Information System (MMIS) for establishment of a prior authorization for approved services against which all claims for payment from providers are compared. The MMIS system also incorporates an edit function that ensures services are only reimbursed to the provider for dates of service on which the participant is Medicaid eligible. The Missouri Medicaid Audit and Compliance (MMAC) within the Department of Social Services 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 MMIS.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

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

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

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

Appendix I: Financial Accountability

g. Additional Payment Arrangements

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

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

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

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

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

iii. Contracts with MCOs, PIHPs or PAHPs.

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

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

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

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver

and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent §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(c) waiver specifies the types of health plans that are used and how payments to these plans are made.

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

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

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

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

Appropriation of State Tax Revenues to the State Medicaid agency

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

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

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

Other State Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

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

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

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

Other Local Government Level Source(s) of Funds.

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

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (3 of 3)**

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

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

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

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

Appendix I: Financial Accountability**I-5: Exclusion of Medicaid Payment for Room and Board**

a. Services Furnished in Residential Settings. Select one:

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

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

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver****Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:**

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

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

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)****a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:**

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

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

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

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

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

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

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

Level(s) of Care: ICF/IID

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|--------|-----------|-----------|-------------|-----------|-----------|-------------|---------------------------------|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 114264.83 | 33732.45 | 147997.28 | 277168.00 | 12841.41 | 290009.41 | 142012.13 |
| 2 | 116682.86 | 36093.73 | 152776.59 | 286868.20 | 14722.68 | 301590.88 | 148814.29 |
| 3 | 119288.39 | 38620.29 | 157908.68 | 296911.80 | 16879.55 | 313791.35 | 155882.67 |
| 4 | 121887.14 | 41323.71 | 163210.85 | 307302.20 | 19352.40 | 326654.60 | 163443.75 |
| 5 | 124562.30 | 44216.37 | 168778.67 | 318056.40 | 22187.53 | 340243.93 | 171465.26 |

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)**

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

Table: J-2-a: Unduplicated Participants

| Waiver Year | Total Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) | |
|-------------|--|---|-----|
| | | Level of Care: | |
| | | ICF/IID | |
| Year 1 | 235 | | 235 |
| Year 2 | 270 | | 270 |
| Year 3 | 305 | | 305 |
| Year 4 | 340 | | 340 |
| Year 5 | 375 | | 375 |

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (2 of 9)**

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

The average length of stay is 340 days. This was calculated by trending forward using historical data regarding the average length of stay from CMS-372 reports, years 2013-2018.

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (3 of 9)**

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

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

Factor D is projected based on the 372 Report data and the actual historic rates/cost of waiver services for State Fiscal Years (SFY) 2013 through 2018.

Waiver Attendant Care (WAC):

Projections are based on 372 Report data for SFY 2013 through 2018. During that time period there was a 9.12% average annual increase in costs and a 1% average annual increase in users. Using those average annual increases, the average cost per user was projected forward through the year 2026. The average annual units per user were then projected by dividing the average annual cost by the projected payment rate per unit of service.

Private Duty Nursing (PDN):

Projections are based on 372 Report data for SFY 2013 through 2018. During that time period there was a 2.2% average annual increase in costs. An average annual increase in users of 35 was determined by looking at multiple factors, including: historical data, increases in participant enrollment, aging caretakers who were previously able to provide for skilled needs but are no longer physically able to do so, anticipated transitions into the program for the next several years, and consideration of the likelihood of outside referrals. Using those average annual increases, the average cost per user was projected forward through the year 2026. The average annual units per user were then projected by dividing the average annual cost by the projected payment rate per unit of service.

Specialized Medical Supplies (SMS):

Projections are based on 372 Report data for SFY 2013 through 2018. During that time period there was a 7.26% average annual increase in costs and a 6.3% average annual increase in users. Using those average annual increases, the average cost per user was projected forward through the year 2026. The average annual units were projected to be 1 per month.

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

Factor D' is projected based on the 372 Report data for State Fiscal Years (SFY) 2014 through 2018.

During that time period there was a 7% average annual increase in costs. The average annual expenditures for factor D' were projected by increasing the 2018 expenditures by 7% annually. Medicare Part D is not a factor in our determination of Factor D'.

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

Factor G is based on the cost for MO HealthNet participants receiving services to meet their complex medical needs in an ICF/IID for State Fiscal Year (SFY) 2017-2019. From SFY 2017-2019, the per diem rate had an average annual increase of 3.5%. The projections for Factor G are derived starting with the SFY 2019 per diem rate of 761.00, with an annual increase of 3.5%, for the next 5 waiver years and then multiplied by the average length of stay on the waiver of 340 days for the average annual expenditures.

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

Factor G' is based on the increase in actual state plan services for participants in an ICF-IID during the State Fiscal Years 2017-2018. There was an increase of 14.65% per participant in state plan services. The average annual expenditures for factor G' were projected by increasing the 2018 expenditures by 14.65% annually. Medicare Part D is not a factor in our determination of Factor G'.

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (4 of 9)**

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

| | |
|------------------------------|--|
| Waiver Services | |
| Waiver Attendant Care | |
| Private Duty Nursing | |
| Specialized Medical Supplies | |

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (5 of 9)****d. Estimate of Factor D.**

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

Waiver Year: Year 1

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|----------|---------|---------------------|-----------------|-------------------|-------------|
| Waiver Attendant Care Total: | | | | | | 359396.68 |
| Waiver Attendant Care | 1/4 hour | 17 | 4575.97 | 4.62 | 359396.68 | |
| Private Duty Nursing Total: | | | | | | 26106051.30 |
| Private Duty Nursing | 1/4 hour | 235 | 13921.00 | 7.98 | 26106051.30 | |
| Specialized Medical Supplies Total: | | | | | | 386786.40 |
| Specialized Medical Supplies | Item | 182 | 12.00 | 177.10 | 386786.40 | |
| GRAND TOTAL: | | | | | | 26852234.38 |
| Total Estimated Unduplicated Participants: | | | | | | 235 |
| Factor D (Divide total by number of participants): | | | | | | 114264.83 |
| Average Length of Stay on the Waiver: | | | | | | 339 |

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (6 of 9)****d. Estimate of Factor D.**

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

Waiver Year: Year 2

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|----------|---------|---------------------|-----------------|-------------------|--|
| Waiver Attendant Care Total: | | | | | | 391128.06 |
| Waiver Attendant Care | 1/4 hour | 17 | 4958.52 | 4.64 | 391128.06 | |
| Private Duty Nursing Total: | | | | | | 30673296.00 |
| Private Duty Nursing | 1/4 hour | 270 | 14060.00 | 8.08 | 30673296.00 | |
| Specialized Medical Supplies Total: | | | | | | 439947.36 |
| Specialized Medical Supplies | Item | 193 | 12.00 | 189.96 | 439947.36 | |
| GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver: | | | | | | 31504371.42 270 116682.86 340 |

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 3

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|----------|---------|---------------------|-----------------|-------------------|--|
| Waiver Attendant Care Total: | | | | | | 451658.58 |
| Waiver Attendant Care | 1/4 hour | 18 | 5373.05 | 4.67 | 451658.58 | |
| Private Duty Nursing Total: | | | | | | 35430074.90 |
| Private Duty Nursing | 1/4 hour | 305 | 14201.00 | 8.18 | 35430074.90 | |
| Specialized Medical Supplies Total: | | | | | | 501225.00 |
| Specialized Medical Supplies | Item | 205 | 12.00 | 203.75 | 501225.00 | |
| GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver: | | | | | | 36382958.48 305 119288.39 340 |

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 4

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|----------|---------|---------------------|-----------------|-------------------|-------------|
| Waiver Attendant Care Total: | | | | | | 491513.50 |
| Waiver Attendant Care | 1/4 hour | 18 | 5822.24 | 4.69 | 491513.50 | |
| Private Duty Nursing Total: | | | | | | 40378413.60 |
| Private Duty Nursing | 1/4 hour | 340 | 14343.00 | 8.28 | 40378413.60 | |
| Specialized Medical Supplies Total: | | | | | | 571700.64 |
| Specialized Medical Supplies | Item | 218 | 12.00 | 218.54 | 571700.64 | |
| GRAND TOTAL: | | | | | | 41441627.74 |
| Total Estimated Unduplicated Participants: | | | | | | 340 |
| Factor D (Divide total by number of participants): | | | | | | 121887.14 |
| Average Length of Stay on the Waiver: | | | | | | 340 |

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 5

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|--|----------|---------|---------------------|-----------------|-------------------|-------------|
| Waiver Attendant Care Total: | | | | | | 536010.94 |
| Waiver Attendant Care | 1/4 hour | 18 | 6308.98 | 4.72 | 536010.94 | |
| Private Duty Nursing Total: | | | | | | 45522255.00 |
| Private Duty Nursing | 1/4 hour | 375 | 14486.00 | 8.38 | 45522255.00 | |
| Specialized Medical Supplies Total: | | | | | | 652597.44 |
| Specialized Medical Supplies | Item | 232 | 12.00 | 234.41 | 652597.44 | |
| GRAND TOTAL: | | | | | | 46710863.38 |
| Total Estimated Unduplicated Participants: | | | | | | 375 |
| Factor D (Divide total by number of participants): | | | | | | 124562.30 |
| Average Length of Stay on the Waiver: | | | | | | 340 |