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

DRAFT

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:
Partnership for Hope

C. Waiver Number:MO.0841

D. Amendment Number:MO.0841.R02.08

E. Proposed Effective Date: (mm/dd/yy)
01/01/23

Approved Effective Date:

Approved Effective Date of Waiver being Amended:

2. Purpose(s) of Amendment

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

The purpose of the waiver amendment:

1. Update the Environmental Accessibility Adaptations-Home/Vehicle Modification maximum limitation
2. Add Value Based Payments for enhanced provider payments to incentivize and reward best practice.
3. Add Level 2 Direct Support Professional (DSP) trained within a year of employment exception for Provider Qualifications, Other Standard provider types: Day Habilitation, Individualized Supported Living, State Plan Personal Care Provider, Community Networking, Family Peer Organization, and Individualized Skill Development.

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	
Appendix C – Participant Services	C-1
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	I-3-c
Appendix J – Cost-Neutrality Demonstration	

A. 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: **Add supplemental/enhanced payment in rates, claims, & billing.**

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*):

Partnership for Hope

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**

Waiver Number:MO.0841.R02.08
Draft ID: MO.020.02.05

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/18
Approved Effective Date of Waiver being Amended: 07/01/18

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 in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

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

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

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

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

PROGRAM PURPOSE

The purpose is to prevent or delay of institutional services for individuals who require minimal services in order to continue living in the community. The waiver will offer prevention services to stabilize individuals primarily living with family members who provide significant support, but are not able to meet all of the individual's needs.

GOALS

To increase access to waiver services for children and adults at the local level in participating counties.

OBJECTIVES

The objectives of the waiver are: 1) to increase the capacity of the State to meet the needs of individuals at risk of institutionalization who require minimal supports to continue living in integrated community settings; 2) to partner with local County Boards through Intergovernmental Agreements in the administration and funding of waiver services; and 3) to implement preventive services in a timely manner in order that eligible participants may continue living in the community with their families.

ORGANIZATIONAL STRUCTURE

The waiver is administered by the Division of Developmental Disabilities (DD) through an interagency agreement with the Department of Social Services, the Single State Medicaid Agency. Through intergovernmental agreements specific waiver administrative tasks are delegated to the boards or other not for profit entities that contract with the Division of DD to provide Targeted Case Management (TCM)services of the participating counties with oversight by the Division of DD, which is the operating agency.

SERVICE DELIVERY METHODS

While traditional service delivery methods will be used, participant-directed services will be an option. As the operational agency for the waiver, the Division of DD's method of service delivery in this waiver is the same as that in 1915(c) waivers operated by this division. Service delivery methods include both provider-managed and participant-directed. Services that may be participant-directed or by an authorized representative are personal assistant, support broker, and community specialist. The state operational agency is responsible eligibility determination, provider credentialing and contracting, prior authorization, claim submission, claim payment, technical assistance and oversight to local agencies, and quality enhancement.

The State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. The state chooses the option to provide HCBS in acute care hospitals under the following conditions.

Ø The HCBS are provided to meet needs of the individual that are not met through the provision of acute care hospital services;

Ø The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;

Ø The HCBS must be identified in the individual's person-centered service plan; and

Ø The HCBS should be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

The 1915(c) HCBS that can be provided by the 1915(c) HCBS provider are not duplicative of services available in the acute care hospital setting.

The 1915(c) HCBS will assist the individual in returning to the community, and are designed to ensure smooth transitions between acute care settings and home and community-based settings.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ○ **No**
- ◉ **Yes**

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

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

Services will only be available to individuals residing in the following Missouri counties:

Adair, Andrew, Audrain, Barry, Barton, Benton, Boone, Buchanan, Caldwell, Callaway, Camden, Cape Girardeau, Cass, Cedar, Chariton, Christian, Clark, Clay, Clinton, Cole, Cooper, Crawford, Dade, Dallas, Daviess, DeKalb, Dent, Franklin, Gasconade, Gentry, Greene, Grundy, Harrison, Henry, Hickory, Holt, Howard, Howell, Iron, Jackson, Jasper, Jefferson, Johnson, Knox, Laclede, Lafayette, Lawrence, Lewis, Lincoln, Linn, Livingston, Macon, Madison, Maries, Marion, McDonald, Mercer, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Newton, Nodaway, Oregon, Osage, Ozark, Perry, Pemiscot, Pettis, Phelps, Pike, Platte, Polk, Pulaski, Putnam, Ralls, Randolph, Ray, Reynolds, Ripley, Saline, Schuyler, Scotland, Scott, Shelby, St. Charles, St. Clair, St. Francois, St. Genevieve, St. Louis City, St. Louis County, Stoddard, Stone, Sullivan, Taney, Texas, Vernon, Warren, Washington, Wayne, Webster and Worth.

Participant direction and other service delivery models are available in all geographic areas where the waiver operates.

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

5. Assurances

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

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

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

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

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

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

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

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

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

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the

procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

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

The Division's Quality Council, which was established in 2006, is comprised of self-advocates and family members. The Council meets quarterly and provides input regarding quality enhancement. The division director and staff from the division's executive management team meet several times each year with the Missouri Developmental Disability Council (formerly Missouri Planning Council), the Missouri Association of County Developmental Disability services, the Missouri Association of Rehabilitation Facilities, and the Missouri ARC. During these meetings, open discussions about the waivers take place. The division periodically assembles ad hoc workgroups to discuss and provide input on specific issues emerging from these discussions. All formal policies and guidelines are developed with stakeholder input, and drafts are posted for comment on the website before finalized and implemented.

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

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

7. Contact Person(s)

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

Last Name: Kremer

First Name: Glenda

Title: Assistant Deputy Director, Program Operations

Agency: Missouri Department of Social Services, MO HealthNet Division

Address: 615 Howerton Court

Address 2: PO Box 6500

City: Jefferson City

State: **Missouri**

Zip: 65102-6500

Phone: (573) 751-6962 **Ext:** ☐ **TTY**

Fax:

(573) 526-4651

E-mail:

Glenda.A.Kremer@dss.mo.gov

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

Last Name:

Luebbering

First Name:

Emily

Title:

Director of Federal Programs

Agency:

Missouri Department of Mental Health, Division of Developmental Disabilities

Address:

1706 E. Elm

Address 2:

P.O. Box 687

City:

Jefferson City

State: **Missouri**

Zip:

65102

Phone:

(573) 522-2941 **Ext:** ☐ **TTY**

Fax:

(573) 526-3308

E-mail:

Emily.Luebbering@dmh.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:

Glenda Kremer

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State

Medicaid Director submits the application.

Last Name: Richardson

First Name: Todd

Title: Director

Agency: MO HealthNet Division

Address: PO Box 6500

Address 2:

City: Jefferson City

State: **Missouri**

Zip: 65102

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

Fax: (573) 751-6564

E-mail: Leann.Hager@dss.mo.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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:

Missouri Department of Mental Health, Division of Developmental Disabilities

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within

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

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

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

The Missouri DSS, MHD, has developed a HCBS waiver quality management strategy that is used to ensure that the operating agency, the Division of DD, is performing its assigned waiver operational functions and administrative functions in accordance with the waiver requirements during the period that the waiver is in effect. MHD and Division of DD meet quarterly to discuss administrative/operational components of the Community Support Waiver. This time is also used to discuss the quality assurances as outlined in Appendix H. Through a Memorandum of Understanding (MOU) that exists between the two (2) agencies, communication remains open and additional discussions occur on an as needed basis.

MHD conducts an analysis of quarterly and annual reports submitted by Division of DD to ensure that the operational functions as outlined in A-7 are being implemented in a quality manner. MHD reviews the information to ensure the following assurances are meeting the established outcomes: 1) Level of Care (LOC), 2) Plan of Care, 3) Qualified Providers, 4) Health and Welfare, 5) Administrative Authority, and 6) Financial Accountability. Meetings take place quarterly and annually between MHD and Division of DD to discuss MHD's analysis of the reports submitted by Division of DD. MHD and Division of DD work together to address any deficiencies, outlining the steps to be taken to ensure the waiver assurances are being met. MHD works closely with Division of DD to set goals and establish timeframes for remediation and improvement activities. If significant problems are identified, MHD may decide to follow-up with a targeted review to ensure the problem is remediated. These findings are again discussed during quarterly quality review meetings.

In addition to Division of DD's ongoing record reviews throughout the year, MHD annually reviews a randomly selected sample of participant records. The MHD provides Division of DD with a findings report and the Division of DD provides remediation and any needed corrective action plan to MHD outlining the steps being taken to address the findings or any problem areas identified. MHD continues to monitor for compliance to ensure that the action steps have been taken in a timely manner.

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

Appendix A: Waiver Administration and Operation

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

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

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

Division of DD has a statewide contract for Vendor Fiscal Employer Agent (VF/EA) Financial Management Services (FMS) that provides administrative functions to support individuals who self-direct services. This is the only contracted entity that provides administrative services to waiver participants. The contractor's responsibilities are specifically related to processing payroll and reporting and paying related taxes and is not responsible for any functions listed in A-7.

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

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

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

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Division of DD is also responsible for monitoring the VF/EA FMS contractor to ensure participants are promptly enrolled, workers are accurately paid, and associated payroll taxes for the employers are deposited.

Appendix A: Waiver Administration and Operation

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

1) Support coordinators employed by regional offices and other approved TCM entities conduct the initial and annual LOC evaluation. The Division of DD Regional Offices provide final approval of eligibility decisions, all support plans, and prior authorizations.

Each Regional Office has a Utilization Review (UR) Committee that meets at least monthly. The committees review all new service plans and budgets and also any service plans and associated budget when an increase in spending is requested. All decisions are subject to the approval of the MHD.

2) Division of DD Regional Office Technical Assistance Coordinators (TAC) conduct quarterly reviews with TCM entities (both local public entities and local non-public entities) that have been delegated waiver administrative functions in the following areas:

a. Participant waiver enrollment
Qualifications of staff;
Evidence the annual support plan was prepared according to guidelines;
Evidence due process and appeals processes are followed;
Accuracy of information entered in the Division's Information system;
Evidence records are maintained for each consumer receiving service coordination; and
Evidence participant was provided choice of waiver service or ICF-ID service.

b. Participant waiver enrollment managed against approved limits

c. LOC evaluation
Qualifications of staff;
Evidence the ICF/ID LOC Form was completed following the procedures;
Evidence the participant was accurately found eligible or ineligible; and
Evidence participants were reevaluated annually by qualified staff, who followed the process; and
Evidence determinations were accurate

d. Review of participant support plans

e. Utilization management
Support plan must have waiver services that are prior authorized;
Support coordinator case notes indicate monitoring was conducted of participants to prevent occurrences of abuse, neglect, and exploitation using risk assessment & planning;
Service authorizations accurately reflect budget and support plan;
Support plans are updated/reviewed at least annually, or when warranted by changes in the participant's needs;
Evidence that provider monthly reviews were done and documented in log notes;
Evidence that quarterly reviews were prepared;
Evidence services were delivered in accordance with the support plan including the type, scope, amount, duration, and frequency as specified in the support plan.

f. Quality assurance and quality improvement activities

3) Annually, MHD reviews case records for a randomly selected group of waiver participants. This is a comprehensive compliance review of all waiver administrative responsibilities. All determinations and decisions by Division of DD and county entities in operating the waiver are subject to approval of the MHD.

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

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the 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 waiver policies/procedures approved by the Medicaid agency prior to implementation. (Number of waiver policies/procedures reviewed prior to implementation/total number of waiver policies/procedures that were reviewed)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of DMH's quality reviews with findings which have been remediated. (Number of DMH's quality reviews with findings that have been remediated by DMH/total number of quality reviews that had findings determined to require remediation.)

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of quarterly meetings held over a waiver year to specifically discuss performance measure findings from Division of DD's quarterly reviews. (Number of quarterly meetings held during the waiver year that focused on findings from Division of DD's quarterly reviews/total number of quarterly meetings that were required to be held.)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of MHD's quality reviews with findings which have been remediated. (Number of MHD's quality reviews with findings that have been remediated by DMH/total number of quality reviews that had findings determined to require remediation.)

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

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

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

Data Aggregation and Analysis:

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

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.

MO HealthNet receives and reviews quarterly reports from the Division of DD in advance of quarterly quality oversight meetings. These reports are discussed with the Division of DD administrative and quality enhancement leadership team prior to quality oversight meetings. These meetings are held to discuss findings from the reports. Findings are discussed and trends are noted and are also discussed at quarterly quality oversight meetings. As needed, MO HealthNet requests additional information and corrective action, based on a review of data reported and discussed. Quarterly quality oversight meeting minutes record discussions and follow-up/remediation actions required of the Division of DD by MO HealthNet.

In addition to quarterly reviews, issues which require individual remediation may come to MO HealthNet's attention through day-to-day activities and communications. Activities may include utilization review and quality review processes or complaints from MHD participants by phone or letter relating to waiver participation/operation.

MHD addresses individual problems as they are discovered by contacting Division of DD and advising them of the issue. A follow-up memo or email is sent from MHD to Division of DD identifying the problem, and if appropriate, a corrective action resolution. While some issues may need to be addressed immediately, remediation activities will be reported to MO HealthNet by the Division of DD as follow-up to these activities, and will also be aggregated in the Division of DD Quality Management Reports. Based upon the situation, MHD will establish an appropriate timeframe for Division of DD to respond. Written documentation is maintained by both MHD and Division of DD, and as needed, discussion will be included during quarterly quality meetings. Any trends or patterns will be discussed and resolved as appropriate.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

An eligible individual has a place to live in the community, typically with family. Unpaid caregiver/family will provide a substantial amount of care. However, the individual requires services and supports in scope or intensity beyond what the primary caregiver(s) is able to provide 24-hours in a day and/or every day of the year. The caregiver's inability to meet all service and support needs puts the individual at risk of out of home placement in an ICF/ID.

An unpaid caregiver/family would include but not be limited to spouses, guardians, step-parent/parents/guardians of minor children which may be considered natural supports. All service definitions specify who may provide the service. Additionally, the planning team delineates between natural supports and paid caregivers.

The individual must be a resident of a participating county upon enrollment and while receiving waiver services.

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 individual support plan (ISP) must validate the individual's annual need for waiver services can be met at a cost of $12,362 or less, or up to $15,000 if the participant meets criteria describe in B-2-c.

The basis for the limit is that individuals participating in this waiver live with family members, have a strong and stable system of natural supports, have support needs that do not warrant participation in either the Community Support or Comprehensive waiver, or have funding from other public programs that in combination with waiver services ensures the individuals have sufficient services and supports to assure their health and safety. Individuals in the PfH waiver will be eligible for MO HealthNet State plan services and will be assisted in accessing those services first. More costly residential services are not included in this waiver.

Individuals are assessed prior to entering this waiver and annually to identify their needs and estimate the cost of waiver services necessary to meet the needs. When additional needs may arise that exceed the cost limits of a particular Division of DD waiver (e.g. Partnership for Hope Waiver) the planning team will support the individual to obtain additional waiver resources to meet the need. If the estimated cost of waiver services exceeds the limit initially or after entering the waiver, the individual is considered for participation in another DD waiver that that can meet their need that does not have a cap.

The regional offices of the operating agency report to the operating agency's central office if the cap becomes too low to meet the needs of a significant number of current participants and/or prospective participants. The cap will be adjusted by amendment if it is determined the cap is not sufficient to meet the needs of a growing number of participants or as a result of system changes such as a statewide provider rate increase.

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

◉ **The following dollar amount:**

Specify dollar amount: 12362

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

can be assured within the cost limit:

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

If an individual is determined not eligible for any reason including due to cost exceeding the cap, the individual will receive written notice of the determination including why the person is not eligible. In addition, the written notice includes the person's right to request a hearing if they believe the determination is in error. The support coordinator will offer assistance in requesting a hearing if assistance is needed. The total annual cost of waiver services identified on the plan of care will be calculated and must not exceed $12,362, unless the criteria described in B-2-c is met.

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

Participants who reside in or move to a county where PfH is not available are informed of the services available where they reside and are served according to the eligibility requirements and prioritization protocols for other waivers. Participants are terminated from the PfH waiver when moving to a county where PfH is not available, and are either enrolled in another waiver, including waivers operated by the DHSS or are placed on the waiting list depending upon the capacity of the other waivers they may be eligible for.

If a participating county withdraws from the program, an individual receiving waiver services through the withdrawing county will continue to receive waiver services until the date 60 days following the county’s withdrawal or until the end of his or her plan year, whichever is later, at which point the individual’s enrollment in the waiver will terminate. During this transition period between the county’s withdrawal from the program and an individual’s termination from the waiver, the Division of DD will work with the individual being disenrolled from the waiver to attempt to find another source of appropriate services for which the individual may be eligible (e.g., another waiver program).

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:

If there is a change in the participant's condition or circumstances which result in increased needs and services to assure the participant's health and welfare, the case manager will propose a change to the plan.

The changed plan will be subject to UR. The UR committee may approve or deny the changes, or may recommend alternative solutions. If increased services are denied, the person will be advised in writing, and will be provided information on appeal rights.

If a proposed plan or proposed change to a plan will cause the annual cap to be exceeded but the service(s) is deemed necessary to protect the person's health and safety and/or prevent the person from entering an institution, an exception can be requested. Exceptions may be approved by the Division of DD Director, or a designee, for a one-time expense, during a crisis or a transition period, or other circumstances supported by a recommendation from the regional office's UR committee.

Individuals participating in the waiver will not lose eligibility for service due to an increased need for a covered service that causes the total need to exceed maximum amounts established by the state.

Examples of action the planning team may take to assist the person in accessing additional services that are required for health and safety and to avoid institutionalization are:

- Seek additional natural supports;
- Consider accessing non-waiver State or County (local) funds;
- Request approval for an exception from the Division of DD Director or designee, to exceed a maximum limitation for a one-time expense, or during a crisis or transition period; and/or

Provide the person information regarding other Missouri waivers such as the DD Comprehensive waiver and provide assistance with applying and transitioning as needed.

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

If an increase in services is approved and there is no alternative means of meeting the needs, an exception may be granted. The County Board or other not for profit entity Director will request the exception. Exceptions must be approved by the Division of DD Director or designee. An exception may be granted to exceed the annual individual cost cap for a one-time expense or during a crisis or transition period in an amount not to exceed $10,000. An exception may be granted to exceed the individual cost cap for an ongoing excess amount of up to $3,000 annually.

There are reserved slots in the Community Support Waiver for crisis and reserve slots in the Comprehensive Waiver for crisis and transition in the event residential supports are necessary.

☒ **Other safeguard(s)**

Specify:

When there is a change in the participant's condition or circumstances the needs of the individual are reevaluated. In some cases, an exception to the cap may be authorized, or the individual may be referred to other services which could include the DD Community Support or Comprehensive Waivers.

An individual is reevaluated as their needs change or the individual requires more significant supports. The change in needs and supports is updated in the person-centered plan, and the individual may transition to another Waiver that offers the services needed.

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	3220
Year 2	3220
Year 3	2875
Year 4	2500
Year 5	2500

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

A. Waiver capacity is allocated to the participating counties named in the geographic area served by this waiver.

B. The methodology used to allocate capacity to participating counties is based on the total number of Medicaid eligible individuals who have been determined eligible for Division of DD services in all of the participating counties, the number of Medicaid eligible individuals who have been determined eligible for Division of DD services in each county, and the number of waiver slots each county requests.

C. Prior to the start of each state fiscal year, each participating county shall inform the Division of DD about the number of waiver slots it will request for that fiscal year. If there are sufficient waiver slots to support each county's request, the State will allocate waiver slots consistent with those county requests, subject to the requirements in paragraph D. If there are not sufficient slots to support each county's request, the State will proportionally decrease each county's allocation based on the percentages described in the first sentence of paragraph D.

D. For each state fiscal year, the State will calculate each county's percentage of the total number of Medicaid eligible individuals who have been determined eligible for Division of DD services within participating counties. For each state fiscal year, the percentage of total funded slots in use that are allocated to each county must be within plus or minus 10% of the percentage describe in the previous sentence.

E. The state assures comparable access to waiver services across the geographic areas served by the waiver and assures that services continue when participants move across geographic areas served by the waiver.

F. Allocation of capacity will be reviewed at least annually or sooner if needed and adjustments will be made according to need.

G. State Division of DD manages the waiting list. When a slot opens up in a particular county, the Division of DD will identify and assign the individual on the waiting list who will take that slot.

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

The following policies apply to the selection of individuals who are otherwise eligible to participate in the PfH Waiver.

When participation is limited, persons whose needs fall into one of the 3 categories under Crisis will be served first. If more than one persons need falls into one of the 3 categories under Crisis, the person waiting the longest is served first. If no one waiting meets a crisis category of need, then the person waiting the longest who meets criteria under Priority will be identified and will be served first. The entity providing case management determines if an individual has needs in the crisis or priority categories.

I. Crisis

Health and safety conditions pose a serious risk of immediate harm or death to the individual or others;

Loss of primary caregiver support or change in caregiver's status to the extent the caregiver can't meet needs of the individual; or

Abuse, neglect or exploitation of the individual.

II. Priority

The individual's circumstances or conditions necessitate substantial accommodation that cannot be reasonably provided by the individual's primary caregiver;

The person has exhausted both their educational and Vocational Rehabilitation (VR) benefits or they are not eligible for VR benefits and they have a need for pre-employment or employment services;

Individual has been receiving supports (other than case management) from local funding for 3 months or more and the services are still needed and the service can be covered by the waiver.

Person living in a non-Medicaid funded residential care facility chooses to transition to the community and has been determined to be capable of residing in a less restrictive environment with access to PfH Waiver Services.

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:

- 42 CFR 435.115 (parents/children receiving 4 mo. extension due to support closing)
- 42 CFR 435.116 (pregnant women)
- 42 CFR 435.117 (newborns deemed eligible)
- 42 CFR 435.118 (infants and children under age 19)
- Section 1925 of the Act (parents/children receiving 6-12 extension due to employment related closing)
- 42 CFR 435.130 (mandatory state supplements)
- 42 CFR 435.145 (children receiving Title IV-E foster care/adoption subsidy)
- 42 CFR 435.150 (former foster children under age 26)
- 42 CFR 435.170 (pregnant women receiving continuous or extended postpartum coverage)
- 42 CFR 435.213 (breast or cervical cancer treatment group)
- 42 CFR 435.222 (reasonable classifications of persons under age 21 -for whom a public agency has full or partial responsibility for while in a foster home, private institution, or non-Title IV-E adoption subsidy)
- 42 CFR 435.229 (optional targeted low-income children)

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

expenses for medical or remedial care (as specified below).

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

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

An approved ISP on the wait list indicates the division has agreed there is a reasonable indication services may be needed in the future.

Initial evaluations and reevaluations are conducted by a qualified support coordinator employed by the Division of DD or TCM Entities approved by the Division of DD to provide TCM. Initial evaluations and reevaluations LOC determinations are approved by the Division of DD Regional Offices and are subject to the approval of the State Medicaid Agency.

- ○ **Other**

Specify:

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

Initial evaluations are conducted by a qualified support coordinator employed by the Division of DD or TCM entities approved by the Division of DD to provide TCM. All LOC determinations are approved by the Division of DD Regional Offices and are subject to the approval of the State Medicaid Agency.

Qualifications of individuals performing LOC evaluations are specified in the Medicaid state plan for TCM for persons with DD approved by CMS effective July 1, 2018.This states that case managers employed by a qualified provider shall have one of the following qualifications: (1) A Registered Nurse; or (2) A Bachelor's degree from an accredited college or university. Case managers employed by a qualified provider on or before June 30, 2018 shall remain qualified.

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

The tool used to evaluate and reevaluate LOC is "Evaluation of Need for an ICF/DD Level of Care and Eligibility for the DD Waiver". An assessment of the individual is conducted before Level of Care Determination the form is completed. The Division uses standard tools to determine level of functioning. Assessment specified in Chapter 2 of 9CSR-45 such as the MOCABI and Vineland are the typical tests of adaptive behavior for all waiver participants. Other formal normative based, standardized assessments of adaptive function may be used to supplement or replace the MOCABI and Vineland. In addition, educational, psychological and medical records, etc. may be used to assist in documenting the individual's diagnosis and level of functioning. These other standardized assessments will not impact eligibility, and current waiver participants will not lose eligibility or services based on these assessments. Any standardized assessment tool utilized will not make it more difficult for an applicant to become waiver eligible. Rather, the tool streamlines the process for applicants, by reducing several different assessments into a single tool.

The Division of DD Waiver ICF/ID LOC must confirm and document the following:
1) The person has an intellectual disability or a related condition;
2) The person has a need for a continuous active treatment program, including aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed toward the improvement of functional abilities, or are necessary to avoid regression or loss of current optimal functioning status; and

3) there is a reasonable indication, based on observation and assessment of the person's physical, mental and environmental condition, that the only alternative services that can meet the individual's needs if waiver services are not available are services through an ICF/ID.

State laws, regulations, and policies concerning LOC criteria and the LOC instrument/tool are available to CMS upon request through the Medicaid agency or the Division of DD.

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

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

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

state plan.

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

The State uses the same tool to determine eligibility for ICF/ID services and eligibility for nursing home services. Therefore, a different process/tool is used to determine eligibility for this waiver. The process/tool is analogous to the initial LOC assessment performed for admission to the ICF/ID and nursing home programs, but is more appropriate to the assessment of persons who have DD. These other standardized assessments will not impact eligibility, and current waiver participants will not lose eligibility or services based on these assessments. Any standardized assessment tool utilized will not make it more difficult for an applicant to become waiver eligible. Rather, the tool streamlines the process for applicants, by reducing several different assessments into a single tool.

The tool walks the evaluator through the process of determining:
1) if the individual has an intellectual disability or a related condition based on identifying substantial functional limitations in 3 or more major life activities;
2) if the individual needs a continuous active treatment program, including aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed towards the acquisition of the behaviors necessary to function with as much self determination and independence as possible; and the prevention of regression or loss of current optimal functional status; and
3) if there is reasonable indication that without access to waiver services the only alternative services that will be available to meet the person's need are ICF/ID services.

The Division of DD Waiver ICF/ID LOC Determination Form is used to determine eligibility. To assess functioning level t he MOCABI or Vineland Vineland are the typical tests of adaptive behavior which are administered to complete the LOC. Other formal normative based, standardized assessments of adaptive function may be used to supplement or replace the MOCABI and Vineland. In addition, educational, psychological and medical records, etc. may be used to assist in documenting the individual's diagnosis and level of functioningThe evaluator is asked to document what assessments and evaluations from the individual's record that wereconsidered. Information from these assessments is used to complete the actual LOC determination form which results in a determination of eligibility or ineligibility

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

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

The following is included in the instructions of the "Evaluation of Need for an ICF/DD Level of Care and Eligibility for the DD Waiver": The Division uses standard tools to determine level of functioning. Assessment specified in Chapter 2 of 9CSR-45 such as the MOCABI and Vineland are the typical tests of adaptive behavior for all waiver participants. Other formal normative based, standardized assessments of adaptive function may be used to supplement or replace the MOCABI and Vineland. In addition, educational, psychological and medical records, etc. may be used to assist in documenting the individual's diagnosis and level of functioning. These other standardized assessments will not impact eligibility, and current waiver participants will not lose eligibility or services based on these assessments. Any standardized assessment tool utilized will not make it more difficult for an applicant to become waiver eligible. Rather, the tool streamlines the process for applicants, by reducing several different assessments into a single tool.

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

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

○ **Other schedule**
Specify the other schedule:

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

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

○ **The qualifications are different.**
Specify the qualifications:

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

Support coordinators employed by the Division of DD regional offices or TCM entities are responsible for reevaluating each participant as part of the annual person centered planning process regarding the individual's continued need for an ICF/ID LOC. Division of DD regional offices must approve claims of eligibility and associated documentation made by TCM entity employees. All decisions are subject to approval of the Medicaid Agency.

The Division of DD Regional Office, in conjunction with the TCM entity providing support coordination, is responsible for ensuring that reevaluations are completed annually. The number of annual re-determinations conducted of all current waiver participants and the number of individuals who continue to be found eligible and the number found to be ineligible are tracked electronically. On a quarterly basis, the QE Leadership Team pulls data to assure compliance with this process as well as implement any necessary corrective action. In addition, Regional Office staff as well as TCM entity staff have direct access to reports to monitor when LOC determinations and formal assessments are coming due. Support Coordinators and Support Coordinator Supervisors receive automated emails as a reminder of upcoming LOC determinations and formal assessments coming due. Support Coordinators enter evaluations electronically. All support coordinators and supervisors have access to centralized data systems in order to verify evaluations are conducted timely.

Quality Management Reports submitted to the MHD by the operating agency and annual sample reviews conducted by the MHD also ensures that a system has been designed and implemented for assuring reevaluations of the LOC need are conducted in a timely manner.

The Division of DD Information System is a comprehensive data base that contains consumer demographics, support coordination information, waiver assignment, dates of evaluations, service plans, provider demographics, services by provider, waiver service authorizations and other information. The Information System also has sophisticated reporting capacity, which is the process used to assure timely evaluations.

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

Evaluation and reevaluation records are located electronically by the Division of DD Information System.

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:
Waiver applicants w/reasonable indications services may be needed having a completed evaluation. (Number of individuals w/reasonable indication services will be needed requesting a waiver slot w/ a completed evaluation in the identified time period divided by Total number of individuals with a reasonable indication services will be needed requesting a waiver slot within the identified time period)

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of initial LOC determinations completed by a qualified staff person. (Initial LOC determinations completed by a qualified staff person divided by Total number of completed initial LOC determinations)

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

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

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

Data Aggregation and Analysis:

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

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 initial LOC determinations using instruments and processes described in the waiver application. (Initial LOC determinations using instruments and processes described in the waiver application divided by total number of completed initial LOC determinations)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of initial LOC determinations completed accurately (Number of initial LOC determinations completed accurately divided by Total number of completed initial Level of Care determinations)

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

On a quarterly basis issues needing remediation are communicated to the TCM TAC Statewide Lead, who then notifies the designated Regional Office TCM TAC in writing within 10 days of the date of discovery. The Regional Office TCM TAC works with support coordination staff to correct the issue. The designated Regional Office TCM TAC enters the issue and remediation into the Division's electronic IQMFD within thirty (30) days describing how the issue was corrected. The TCM TAC's complete a quarterly analysis of data to identify trends of TCM entities which is shared with TCM and Regional Office Management to determine what improvement activities to initiate based on the trend.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Support Coordinators employed by Division of DD Regional Offices and TCM entities approved to provide case management explain to individuals the choice between ICF/ID institutional services and Home and Community Based services (HCBS). Support coordinators educate individuals/guardians regarding all waiver services and providers available. This will be completed by the support coordinator reviewing options with the individuals/guardians, then the individuals may meet with providers to make their selection.

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Day Habilitation**		
Statutory Service	**Personal Assistant Services**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Supported Employment**		
Extended State Plan Service	**Dental**		
Supports for Participant Direction	**Support Broker**		
Other Service	**Applied Behavior Analysis (ABA)**		
Other Service	**Assistive Technology**		
Other Service	**Benefits Planning**		
Other Service	**Career Planning**		
Other Service	**Community Networking**		
Other Service	**Community Specialist**		
Other Service	**Community Transition**		
Other Service	**Environmental Accessibility Adaptations-Home/Vehicle Modification**		
Other Service	**Family Peer Support**		
Other Service	**Individual Directed Goods and Services**		
Other Service	**Individualized Skill Development**		
Other Service	**Job Development**		
Other Service	**Occupational Therapy**		
Other Service	**Physical Therapy**		
Other Service	**Professional Assessment and Monitoring**		
Other Service	**Specialized Medical Equipment and Supplies (Adaptive Equipment)**		
Other Service	**Speech Therapy**		

Service Type	Service
Other Service	Temporary Residential Service
Other Service	Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Day Habilitation services are designed to assist the individual to acquire, improve and retain the self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. Day Habilitation services may also be used to provide supported retirement activities. As people get older they may no longer desire to work and may need support to assist them in meaningful retirement activities. This might involve altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs, and/or other senior related activities in their communities. Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered service plan, such as physical, occupational, or speech therapy. Day Habilitation may not provide services that are vocational in nature.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Activities should be appropriate to the setting and occur in the most natural setting possible to maximize transference of skill acquisition.

This service does not provide basic child care (a.k.a. "baby sitting"). When services are provided to children the individual support plan (ISP) must clearly document that services are medically necessary to support and promote the development of independent living skills of the child or youth, and are over and above those provided to a child without disabilities. The ISP must document how the service will be used to reinforce skills or lessons taught in school, therapy or other settings and neither duplicates nor supplants the services provided in school, therapy or other settings. ISPs must include outcomes and action steps individualized to what the participant wishes to accomplish, learn and/or change. The UR Committee, authorized under 9 CSR 45-2.017 has the responsibility to ensure all services authorized are necessary based on the needs of the individual and ensures that Day Habilitation services is not utilized in lieu of basic child care that would be provided to children without disabilities.

Day habilitation services provide regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Day Habilitation services are provided in part with a stand-alone certified day habilitation facility and should be provided in any of a variety of settings in the community and are not limited to fixed site facilities. Costs for transporting the participant from their place of residence to the place where day habilitation services are provided is not included in the day service rate, but may be provided and billed separately as a waiver transportation service. Transportation needed to participate in community activities as a part of the Day Habilitation service is included in the service.

Meals provided as part of these services do not constitute a full nutritional regiment.

Medical Exception:
People with exceptional medical supports needs may be granted a medical exception. Exceptional medical supports require services from the following: a Certified Nursing Assistance (CNA), a licensed practical nurse within their scope of practice as prescribed by the state law, a registered nurse, or, for mobility, by appropriately trained staff. The process must include the identification and rationale for staffing ratios and the level of direct care provided to meet the identified needs and be clearly documented in their service plan. The process shall include a component of professional assessment by licensed interdisciplinary team member (RN, primary care physician, OT, PT, SLP, etc.).

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

Unlicensed Health Care Personnel shall be defined as the following:
- a DHSS Certified Restorative Aide
- a DHSS Certified Medication Technician(CMT)
- a DHSS Certified Nursing Assistant (CNA)
- a DHSS Certified Level I Medication Aide(LIMA)
- a DMH DD Certified Medication Aide or
- a DMH DD Direct Support Professional

This is to promote individuals ability to access community based services and integration to the fullest extent of their capabilities. A separate rate and procedure code and modifier is available for this service.

Requests for Medical Exceptional must be reviewed and approved the UR Committee and include the following documentation:
- Written Support Plan which includes clinical outcome data with criteria for reduction of supports as relevant to the identified medical condition(s).
- Written documentation noting the individual's assessed need for medical or mobility by the individual's medical practitioner.

Behavior Exception:
People with exceptional behavioral support needs may be granted a behavior exception when additional staffing is required to keep them and/or others safe. Requests for a Behavioral Exception shall be submitted to the UR committee and include one of the following types of documentation:

- An ISP inclusive of a Behavior Support Plan including supports to be implemented through the Day Habilitation service and confirmation of ongoing applied behavior analysis services.

or
- An approved ISP documenting behavior supports have been recommended and are being pursued

Personal Assistant services may be a component of Day Habilitation as necessary for the individual to participate in the service but may not comprise the entirety of the service.

A separate rate and procedure code and modifier is available for this service. This is to promote individuals ability to access community based services and integration to the fullest extent of their capabilities. (A Behavioral Exception is to ensure people with significant behavioral support needs have access to the community to the fullest extent possible.)

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Habilitation

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Day Habilitation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010 certification; Commission on Accreditation of Rehabilitation Facilities (CARF), The Council on Quality and Leadership (CQL) or The Joint Commission

Other Standard *(specify):*

DMH Contract;
Direct contact staff must have the following:
A high school diploma or its equivalent,
or Level 2 Direct Support Professional
(DSP) trained within a year of
employment; training in CPR/First Aid;

Program staff administering medication must have successfully completed a course on medication

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval and every three years; as needed based on service monitoring concerns.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Assistant Services

HCBS Taxonomy:

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

08 Home-Based Services	08030 personal care

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

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

Service Definition *(Scope):*

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

Personal Assistant Services include a range of assistance for any activities of daily living (ADL) or instrumental activity of daily living (IADL) to enable individuals to complete tasks they are not able to do for themselves due to their disability. This may take the form of hands on assistance (actually performing a task for the individual), cueing to the individual to perform a task, or performing the task for the individual if they are not able to do for themselves. Personal assistant services provide support and incidental teaching to assist the individual to participate fully in their home and community life. These supports can be provided in the participant's own home, family home, and in the community, and always provided in the presence of the individual.

While Personal Assistant service is ordinarily provided on a one-to-one basis, personal assistance may be delivered to groups of individuals when it is determined to meet the individuals' needs. With written approval from the Regional Office Director, personal assistant services may be delivered to groups of four (4) to six (6) persons when it is determined the needs of each individual in the group can be safely met.

Personal Assistant staff are required to be awake at all times. Personal Assistant Services may be provided on an episodic or continuing basis. Personal Assistant Services may be provided by an agency or as a self-directed option.

Relatives as Providers:
Relatives (parent, step-parent, foster parent, sibling, child (by blood, adoption, or marriage), spouse, grandparent, or grandchild) may be approved to provide personal assistant services through an agency or self-directed with exceptions listed below.
The following cannot be a provider of personal assistant services:
- Individual's spouse
- Parent, step-parent, or foster parent of a minor child (under age 18)
- The individual's guardian
- Self-directed supports designated representative or employer of record

When a relative provides personal assistance, the ISP must reflect:
• The individual is not opposed to the relative providing the services;
• The planning team determines the paid relative providing the service best meets the individual's needs;
• The services to be provided are solely for the individual and not the benefit of the household/family unit;
• A relative will only be paid for the hours authorized in the support plan and at no time can these exceed 40 hours per week. Any support provided above this amount would be considered a natural support or the unpaid care that a family member would typically provide.
Difference between State Plan Personal Care and DD waiver Personal Assistant Services
Personal Assistant Service under the waiver differs in scope, nature, supervision arrangements, limitation of amount, and/or provider type from personal care services in the State Plan.
Personal Assistant Services (PA) differ from State Plan in the following ways:
- PA may be provided in the community.
- PA must always be provided in the presence of the individual receiving the service.
- PA can provide support with medication administration and management. (Personal Assistant, Medical, unless self-directed)
- PA can provide specialized healthcare and medical tasks or tasks requiring nursing delegation (Personal Assistant, Medical, unless self-directed)
- PA may be self-directed through the use of a designated representative

When an individual's need for personal assistant service can be met through the MO HealthNet state plan personal care program administered by the Division of Senior and Disability Services (DSDS) with the Missouri Department of Health and Senior Services (DHSS), he or she will not be eligible for Personal Assistant Services under the waiver, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided.
After State Plan Personal Services have been exhausted, DD Waiver personal assistant may be authorized when:
• State plan limits on number of units for personal care are reached and more assistance with ADLs and/or IADLs is needed;
• The individual has medical needs and they require a more highly trained personal assistant than is available under state plan;
•When the personal assistant worker is related to the individual; or
•When the individual or family is directing the service through the Vendor Fiscal Employer Agent (VF/EA) Financial Management Services (FMS) contractor.
When waiver personal assistant is authorized to adults also eligible for state plan personal care, the Support

coordinator must consult and coordinate the waiver support plan with the DSDS service authorization system.
Personal care services are provided to children with disabilities according to the federal mandates of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. Personal Assistant needs for the eligible individual through EPSDT, as applicable, shall be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Personal Assistant services authorized through the waiver shall not duplicate state plan personal care services. State plan personal care services for children are coordinated through the Bureau of Special Health Care Needs (BSHCN) through DHSS.
When waiver personal assistant is authorized for children also eligible for state plan personal care, the Support Coordinator must consult and coordinate with the BSHCN service authorization system.
Personal Assistant, Self-Directed option
Self-Directed Supports is an option of service delivery for individuals who wish to exercise more choice, control and authority over their supports.
Team Collaboration, Self-directed option
Team collaboration is available under Self-Directed Services only. Team collaboration allows the individual's employees to participate in the Individual Support Plan and to meet as a team to ensure consistency in its implementation. A team meeting also can be convened by the individual or their designated representative for the purposes of discussing specific needs of the individual, the individualized progress towards outcomes, and other related concerns. Team collaboration can be included in the individual budget limited to 120 hours per plan year. Team collaboration is included in the rate for agency-based personal assistant services.
Personal Assistant, Medical option (Agency or Self-directed)
To assist in meeting the specialized medical needs for the individual as identified by the team and documented in the ISP, the following must have been met:
• The interdisciplinary team has identified and outlined the need to pursue more intensive support for medically related issues;
•The need must be documented by a physician or advanced practice nurse and maintained on file;
• Prior to approval of funding for medical personal assistance the ISP has gone through the local UR review process to determine the above have been completed.
• Depending upon the scope of services, a registered professional nurse may be required to provide oversight in accordance with the Missouri Nurse Practice Act.

For individuals hospitalized, personal assistant services may be provided to assist with supports, supervision, communication, and any other supports that the hospital is unable to provide. The service will: be identified in an individual's person-centered service plan; provided to meet needs of the individual that are not met through the provision of hospital services; not substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and be designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

For individuals hospitalized, personal assistant services may be provided to assist with supports, supervision, communication, and any other supports that the hospital is unable to provide. The service will: be identified in an individual's person-centered service plan; provided to meet needs of the individual that are not met through the provision of hospital services; not substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and be designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

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

Individuals who receive Group Home, Individualized Supported Living, or Shared Living may not receive this service.

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

Personal Services through EPSDT for eligible persons under age 21 shall be provided and utilized first before the waiver Personal Assistant Service is provided. Children have access to EPSDT services.

Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

The services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self-Directed Supports
Agency	A Medicaid-enrolled provider of personal care services
Agency	Day Habilitation Services
Individual	Independent Contractor
Agency	Assistive Technology Provider
Agency	Individualized Supported Living Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant Services

Provider Category:
Individual
Provider Type:

Self-Directed Supports
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Age 18; has completed Abuse and Neglect training/reporting events and training on the ISP; meets minimum training requirements; agreement with individual/designated representative;
Shall not be the individual's spouse; a parent, step-parent or foster parent of an individual (under age 18); a legal guardian; nor the employer of record/or a designated representative for the individual.
The individual shall not be opposed to the family member providing care.
The planning team agrees the family member providing the personal assistant service will best meet the individual's needs.
Family members employed by the individual or designated representative are supervised by the individual or a designated representative in providing service in the home or community consistent with the service plan.
The planning team led by the individual/designated representative will specify the qualifications and training the personal assistant will need in order to carry out the support plan;
Supervision is provided by the individual or a designated representative in providing service in the home or community consistent with the support plan.
Personal Assistant Qualifications and Training
Training will cover, at a minimum:
a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Support Plan.
b. The rights and responsibilities of the employee and the individual, procedures for billing and payment, reporting and documentation requirements, procedures for arranging backup when needed, and who to contact within the Regional Office or TCM entity.
c. Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
d. Training in abuse/neglect, event reporting, and confidentiality.
e. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
f. CPR and first aid;
g. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
h. Crisis intervention training as needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
i. training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
j. Training in assisting with ADLs and IADLs, as needed by the individual to be served and identified by the team.

For Self Directed Supports the planning team led by the individual/designated representative will specify the qualifications and training the personal assistant will need in order to carry out the support plan. The individual or designated representative will select the personal assistant and carry out training and supervision.

Individual/guardian or designated representative may exempt the following trainings when the Personal Assistant will not require skills to be attained from the trainings;
- CPR and first aid;
- Medication Administration;
- Crisis intervention training as needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual; Designated Representative; VF/EA FMS; Regional office has oversight

Frequency of Verification:

VF/EA FMS verifies on behalf of individual/designated representative prior to hire.
Prior to signed agreement with regional office and individual/designated representative; service review as needed based on service monitoring concerns; as individual needs change.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant Services

Provider Category:

Agency

Provider Type:

A Medicaid-enrolled provider of personal care services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Medicaid-enrolled Personal Care services provider
Personal Assistant Qualifications and Training
Training will cover, at a minimum:
a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Support Plan.
b. Training in abuse/neglect, event reporting, and confidentiality.
c. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
d. CPR and first aid;
e. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
f. Crisis intervention training As needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional office staff

Frequency of Verification:

Prior to contract approval; regional office monitors provider every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant Services

Provider Category:

Agency

Provider Type:

Day Habilitation Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DMH Certification for day habilitation; or CARF/CQL/Joint commission accredited for day habilitation

Other Standard *(specify):*

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

Personal Assistant Qualifications and Training
Training will cover, at a minimum:
a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Support Plan.
b. Training in abuse/neglect, event reporting, and confidentiality.
c. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
d. CPR and first aid;
e. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
f. Crisis intervention training as needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office Staff

Frequency of Verification:

Prior to contract approval; regional office monitors provider every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Assistant Services

Provider Category:

Individual

Provider Type:

Independent Contractor

Provider Qualifications

License *(specify):*

Missouri State professional license such as RN or LPN.

Certificate *(specify):*

Other Standard *(specify):*

DMH Contract;
Shall not be the individual's spouse; a parent or a step-parent of an individual under age 18; a legal guardian; nor the employer of record/or a designated representative for the individual.
Personal Assistant Qualifications and Training
Training will cover, at a minimum:
a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Support Plan.
b. Training in abuse/neglect, event reporting, and confidentiality.
c. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
d. CPR and first aid;
e. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
f. Crisis intervention training as needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office staff

Frequency of Verification:

Prior to contract approval; regional office monitors provider every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant Services

Provider Category:

Agency

Provider Type:

Assistive Technology Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The monitoring agency must be capable of simultaneously responding to multiple signals for help from the individual's Personal Emergency Response Systems (PERS) equipment. The monitoring agency's equipment must include a primary receiver, a stand-by information retrieval system and a separate telephone service, a stand-by receiver, a stand-by backup power supply, and a telephone line monitor. The primary receiver and back-up receiver must be independent and interchangeable. The clock printer must print out the time and date of the emergency signal, the individual's PERS Medical identification code (PIC) and the emergency code that indicates whether the signal is active, passive, or a responder test. The telephone line monitor must give visual and audible signals when an incoming telephone line is disconnected for more than 10 seconds. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements including PERS equipment installation, functioning and testing; emergency response protocols; and record keeping and reporting procedures.
DMH Contract.
Registered and in good standing with the Missouri Secretary of State.
Personal Assistant Qualifications and Training
Training will cover, at a minimum:
a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual’s Support Plan.
b. Training in abuse/neglect, event reporting, and confidentiality.
c. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
d. CPR and first aid;
e. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
f. Crisis intervention training As needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office staff

Frequency of Verification:

Prior to contract approval; regional office monitors provider every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant Services

Provider Category:

Agency

Provider Type:

Individualized Supported Living Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DMH Certification for ISL; or CARF/CQL/Joint Commission accredited for ISL services.

Other Standard *(specify):*

DMH Contract;
The agency-based provider of personal assistance must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; and the planning team may specify additional qualifications and training necessary to carry out the service plan.
Personal Assistant Qualifications and Training
Training will cover, at a minimum:
a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Support Plan.
b. Training in abuse/neglect, event reporting, and confidentiality.
c. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
d. CPR and first aid;
e. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
f. Crisis intervention training As needed, due to challenging behavior by the Individual, the assistant will also be trained in crisis intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office staff

Frequency of Verification:

Prior to contract approval; regional office monitors provider every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Prevocational Services provide one-to-one learning and group experiences to further develop an individual's general, non-job-task-specific skills needed to succeed in competitive, integrated employment (work settings where compensation is at or above minimum wage). Services are expected to occur over a defined period of time with specific and measurable outcomes to be achieved. Services prepare the individual to attain the highest level of independence and autonomy in the most integrated employment setting aligned with the individual's interests, abilities, and capabilities.

Prevocational services includes activities that are primarily directed at assisting an individual with developing non-job task specific skills that are associated with performing competitive work in community integrated employment. Providers of this service may coordinate, evaluate and communicate not only with the individual but, also with community businesses to develop unpaid work experiences. This service should be provided in the presence of the individual to the maximum extent possible and should be conducted in the community to the maximum extent possible but completion of activities without the presence of the individual should not be precluded.

Prevocational services may include volunteering, uncompensated work experience and compensated work experience settings to support the development of expanded habilitation skills. Any limitations on location or duration of these experiences are established and governed through the US Department of Labor (DOL) Fair Labor Standards Act and Wage and Hour Laws. It is the service provider's responsibility to understand these industry specific term and act in accordance to DOL regulations.

Services may be provided in a community setting or at a certified or accredited facility of a qualified employment service provider. The setting for the delivery of services must be aligned with the individualized assessed need and that which is most conducive in developing the specific and measurable outcomes contained within the Individual Support Plan. Services cannot be provided within an individual's residence.

Services are intended to develop and teach expanded habilitative skills that lead to competitive and integrated employment including, but not limited to:

- Communication with supervisors, co-workers and customers
- Work appropriate conduct, hygiene and dress
- Workplace problem solving skills
- Use of strategies, to include assistive technology, for task attendance and completion
- Workplace safety skills
- Mobility and motor skills training
- Asset development and financial literacy

Vocational services, which are not covered through home and community based waivers, are job task specific skills training required by a participant for the primary purpose of completing those tasks for a specific facility based job or those delivered in a segregated setting. The distinction between vocational and pre-vocational services is that Prevocational Services are delivered for the purpose of furthering habilitation goals that will lead to greater opportunities for competitive integrated employment or further career advancement.

Participation in Prevocational Services is not a pre-requisite for supported employment services. Prevocational Services should only be authorized when an individual is otherwise unable to directly enter the general workforce as a result of an underdeveloped or undeveloped general, non-job-task-specific skill(s).

Prevocational Services can be provided in small groups not exceeding four (4) individuals at a time. The decision to provide services in a group setting must be based on individualized assessed need and be supported in the person centered plan as being the most autonomous setting which facilitates the highest levels of individual learning.

The provision of Prevocational Services is always delivered with the intention of developing skills which will lead to competitive integrated employment. Volunteering for personal reasons not related to future employment would not be Prevocational Services.

All Prevocational Services should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals.

Personal Assistant services may be a component of Prevocational service as necessary for the individual to participate in the service but may not comprise the entirety of the service.

- Transportation costs for the implementation of Prevocational Services are included in the unit rate .

Prevocational Services furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 and its amendments or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Therefore, the case record for any individual receiving this service must document the individual is not eligible for, unable to access, exhausted services or otherwise inapplicable for the aforementioned programs as outlined in an interagency MOU between Vocational Rehabilitation and the Division of DD.

Prevocational services must comply with 42 CFR §440.180(c) (2) (i).

Outcomes expected for this service are as follows:
Monthly plan describing the progress on skill acquisition and ongoing development needed to be prepared for employment.

Service Documentation:
Providers of Prevocational Services must maintain an individualized plan and detailed record of activities by unit of service.

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

Must be authorized based upon individual need not to exceed 2,080 units per annual support plan year. Additional units may be approved by the Division's Regional Director or designee in exceptional circumstances.

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	Employment Services Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:

Employment Services Provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010 certification; CARF or CQL accreditation

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval and every three years;

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03022 ongoing supported employment, group
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported employment is a support service to facilitate competitive work in an integrated work setting. The service must be identified in the individual's service plan based upon an individualized assessed need which promotes the greatest degree of integration, independence and autonomy. Models of supported employment may include individual support or group support such as community business-based work groups and or mobile crews. Individual and group services are defined separately below.
For those individuals whose individualized assessed need supports self-employment, Supported Employment Individual employment supports may include services and supports that assist the individual in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include ongoing assistance, counseling and guidance once the business has been launched.
Assistance for self-employment may include:

- Aide to the individual in identifying potential business opportunities;
- Assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; and
- Identification of the supports that are necessary for the individual to operate the business.

Supported Employment- Individual Supported Employment
Individual Supported Employment services are the ongoing supports to individuals and their employers who, because of their disabilities, need intensive on-going support to maintain a job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported Employment - Individual Supported Employment services may include:

- On-the-job training in work and work-related skills; i.e. job coaching to facilitate the acquisition, and ongoing performance, of the essential functions of the job and the facilitation of natural supports (i.e. fading).
- Ongoing retention, supervision and monitoring of the person's performance; i.e. evaluating self-maintenance strategies, work production and the effectiveness of natural supports (i.e. fading) which promote the greatest degree of inclusion, integration and autonomy.
- Training in related skills needed to retain employment; i.e. supporting and facilitating strategies which promote inclusion in the workplace based upon individualized assessed need such as using assistive devices, community resources and public transportation. This service should be provided in the presence of the individual to the maximum extent possible but completion of activities without the presence of the individual should not be precluded.

Supported Employment -Small Group Employment Support:
Group supported employment are services and training activities provided in regular community business and industry settings for groups of two (2) to four (4) workers with disabilities. Small group employment support does not include services provided in facility based work settings or non-integrated work settings (i.e. settings which physically and socially isolate individuals from other employees). Examples include mobile crews and other community business-based workgroups employing small groups of workers with disabilities in integrated competitive employment in the community. The outcome of this service is sustained paid employment, work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. An annual review must occur to determine if the employment setting optimizes, but does not regiment, individual initiative, autonomy and independence in making employment choices.

Supported Employment – Small Group Employment Supports may include:

- On-the-job training in work and work-related skills; i.e. job coaching to facilitate the acquisition, and ongoing performance, of the essential functions of the job and the facilitation of natural supports (i.e. fading).
- Ongoing supervision and monitoring of the person's performance on the job; i.e. evaluating self-maintenance strategies, work production and the effectiveness of natural supports (i.e. fading) which promote the greatest degree of inclusion, integration and autonomy.
- Training in related skills needed to retain individual integrated community-based employment; i.e. supporting and facilitating strategies which promote attendance and social inclusion in the workplace based upon individualized

assessed need such as using community resources and public transportation.

Additional Information about Supported Employment services:

- Supported employment services must be provided in a manner that promotes integration into the workplace and interaction between individuals and people without disabilities in those workplaces while maintaining the individual's rights of dignity, privacy and respect.
- All Supported Employment service options should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's assessed goals, needs, interests and preferences. Supported Employment Group is not appropriate for individuals who demonstrate the capacity, ability and interest to work independently. An individual's autonomy and independence to perform employment with the least amount of restrictions must be supported through the person centered planning process.
- Supported Employment supports do not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business or otherwise covered under the Americans with Disabilities Act.

Supported Employment may include assistance with reporting and managing earnings with Social Security and Medicaid.

- However, Personal Assistance Service may not be used in lieu of Supported Employment services as defined above.

Personal Assistant services may be a component of Supported employment as necessary for the individual to participate in the service but may not comprise the entirety of the service.

- Transportation costs are not included in the supported employment rate . Transportation is available as a separate service if necessary and able to be coordinated through the person centered planning team.

Supported Employment furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 and its amendments or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Therefore, the case record for any individual receiving this service must document the individual is not eligible for, unable to access, exhausted services or otherwise inapplicable for the aforementioned programs as outlined in an interagency memorandum of understanding between Vocational Rehabilitation and the Division of Developmental Disabilities.

Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; or
2) Payments that are passed through to users of supported employment programs.

Outcomes expected for this service are as follows:

Monthly retention plan describing the results of the professional observation and assessment of the individual and their current and needed paid/unpaid supports to sustain employment. The retention plan includes a summary of implementation strategies to maximize employment, independence, natural supports, job performance and addressing any identified potential risk associated with reduction of paid supports.

Service Documentation:

Providers of Supported Employment must maintain an individualized plan and detailed record of monthly activities by unit of service.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Employment Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Employment Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010 certification; CARF, CQL accreditation

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval and every three years;

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Dental

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11070 dental services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Preventive dental treatment-topical fluoride applications. Therapeutic dental treatment-pulp therapy for permanent teeth; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable.

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

Dental services for individuals under the age of 21 are not covered. Dental services for individuals under the age of 21 may be accessed under the State plan as a Healthy Children and Youth (HCY/EPSDT) benefit. This waiver service is only provided to individuals age 21 and over. All medically necessary “Dental” services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. The dental services are limited to additional services not otherwise covered under the state plan.

Dental services for adults exclude the following:
Any service that may be covered under the State plan Medicaid program.
The following dental services may require prior authorization: treatment for trauma of the mouth, jaw, teeth, or other contiguous sites as a result of an injury; and treatment of a disease/medical condition without which the health of the individual would be adversely affected and would result in a higher level of care. It also includes preventive services, restorative services, periodontal treatment, oral surgery, extractions, radiographs, pain evaluation and management, infection control, and general anesthesia.

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	Dental Clinic
Individual	Dentist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Dental

Provider Category:

Agency

Provider Type:

Dental Clinic

Provider Qualifications

License *(specify):*

Current State license as a dentist in the State of Missouri or a state bordering Missouri; licensed dental hygenist or dental assistant. RSMo. 332.031 and 332.211.

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with MO HealthNet to provide State plan dental services.
DMH Contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Dental

Provider Category:

Individual

Provider Type:

Dentist

Provider Qualifications

License *(specify):*

Current State license as a dentist in the State of Missouri or a state bordering Missouri. RSMo. 332.031 and 332.211.

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with MO HealthNet to provide State plan dental services.
DMH Contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Support Broker

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

A Support Broker provides the individual or their designated representative with information & assistance (I&A) to secure the supports and services identified in the Support Plan.

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

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

Support Broker services do not duplicate Support Coordination. Support Brokerage is a direct service.

A Support Broker may not be a parent, guardian or other family member. A support broker cannot serve as a self-directed personal assistant for that individual. This service can be authorized for up to 32 units per day (8 hours)

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Day Habilitation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010 certification for Day Habilitation; CARF; CQL or the Joint Commission accredited for Day Habilitation

Other Standard *(specify):*

DMH Contract; employs qualified support brokers
Support brokers must have a background screening per the Division of DD, be at least 18 years of age and possess a high school diploma or GED, or Level 2 Direct Support Professional (DSP) trained within a year of employment.
The support broker must have experience or Division DD approved training in the following areas:
• ability, experience and/or education to assist the individual/designated representative in the specific areas of support as described in the Service Plan &
• competence in knowledge of Division of DD policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
• understanding of support broker responsibilities, of advocacy, person-centered planning, and community services; and
• understanding of individual budgets and Division of DD fiscal management policies.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

State Plan Personal Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DMH Contract; MO HealthNet Personal Care Enrollment; employs qualified support brokers.
Support brokers must have a background screening per the Division of DD, be at least 18 years of age and possess a high school diploma or GED or Level 2 Direct Support Professional (DSP) trained within a year of employment.
The support broker must have experience or Division DD approved training in the following areas:
• ability, experience and/or education to assist the individual/designated representative in the specific areas of support as described in the Service Plan &
• competence in knowledge of Division of DD policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
• understanding of support broker responsibilities, of advocacy, person-centered planning, and community services; and
• understanding of individual budgets and Division of DD fiscal management policies.
The planning team may specify any additional qualifications and training the support broker will need in order to carry out their duties as specified in the Support Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Community Networking

Provider Qualifications

License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010 certification for Community Networking; CARF; CQL or The Joint Commission accreditation

Other Standard *(specify):*

DMH contract; employs qualified support brokers
Support brokers must have a background screening per the Division of DD, be at least 18 years of age and possess a high school diploma or GED or Level 2 Direct Support Professional (DSP) trained within a year of employment.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Individualized Supported Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DMH Certification for ISL; or CARF/CQL/Joint Commission accredited for ISL

Other Standard *(specify):*

DMH Contract; employs qualified support brokers
Support brokers must have a background screening per the Division of DD, be at least 18 years of age and possess a high school diploma or GED, or Level 2 Direct Support Professional (DSP) trained within a year of employment.
The support broker must have experience or Division DD approved training in the following areas:
• ability, experience and/or education to assist the individual/designated representative in the specific areas of support as described in the Service Plan &
• competence in knowledge of Division of DD policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
• understanding of support broker responsibilities, of advocacy, person-centered planning, and community services; and
• understanding of individual budgets and Division of DD fiscal management policies.
The planning team may specify any additional qualifications and training the support broker will need in order to carry out their duties as specified in the Support Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Applied Behavior Analysis (ABA)

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

ABA services are designed to help individuals demonstrating significant deficits (challenges) in the areas of behavior, social, and communication skills acquire functional skills in their homes and community and/or to prevent hospitalizations or out-of-home placements. ABA may be provided to assist a person(s) to learn new behavior directly related to existing challenging behaviors or functionally equivalent replacement behaviors for identified challenging behaviors. ABA may also be provided to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. ABA includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior. The Behavior Support Plan (BSP) should describe strategies and procedures to generalize and maintain the effects of the BSP and to collect data to assess the effectiveness of the plan and fidelity of implementation of the plan. The specific skills and behaviors targeted for each individual should be clearly defined in observable terms and measured carefully by direct observation each session. The BSP shall include collection of data by the staff, family and or caregivers that are the primary implementers of the plan and the service shall include monitoring of data from continuous assessment of the individual's skills in learning, communication, social competence, and self-care guide to the scope of the individual support plan, which must include separate, measurable goals and objectives with clear definitions of what constitutes mastery. Reports regarding the service must include data displayed in graphic format with relevant environmental variables that might affect the target behaviors indicated on the graph. The graph should provide indication of analysis via inclusion of environmental variables including medications and changes in medications, baseline or pre-intervention levels of behavior, and strategy changes. Performance-based training for parents, caregivers and significant others in the person's life is also part of the behavior analysis services if these people are integral to the implementation or monitoring of the plan. ABA consists of the following components: Assessment: ABA services are based on an assessment which identifies functional relationships between behavior and the environment, including contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical variables related to challenging behaviors or situations. The assessment is further composed of the following elements: Behavior identification assessment, by the physician or other QHCP, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report. Observational Behavioral Follow-up Assessment: May be required to enable the QHCP to finalize or fine-tune the baseline results and plan of care that were initiated in the identification assessment. This is performed by a technician under the direction of a QHCP or licensed assistant behavior analyst (LaBA). The QHCP or LaBA may or may not be on-site during the face-to-face assessment process. This is provided to individuals who present with specific destructive behavior(s) (e.g. self-injurious behavior, aggression, property destruction) or behaviors or deficits in communication or social relatedness. This includes the use of structured observation and/or standardized and non-standardized tests to determine levels of adaptive behavior. Areas assessed may include cooperation, motivation, visual understanding, receptive and expressive language, imitation, requests, labeling, play and leisure and social interactions. Specific destructive behavior(s) assessments include structured observational testing to examine events, cues, responses, and consequences associated with the behavior(s). Behavior Identification Supporting Assessment: is administered by the QHCP with the assistance of one or more technicians. This assessment includes the QHCP's interpretation of results, discussion of findings and recommendations with primary caregiver(s), and preparation of report. Typical individuals for these services include those with more specific severe destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction). Specific severe destructive behavior(s) are assessed using structured testing to examine events, cues, responses, and consequences associated with the behavior. This includes exposing the individual to a series of social and environmental conditions associated with the destructive behavior(s). Assessment methods include using testing methods designed to examine triggers, events, cues, responses, and consequences associated with the before mentioned maladaptive behavior(s). This is completed in a structured, safe environment. Treatment: Adaptive Behavior Treatment: Addresses the individual's specific target problems and treatment goals as defined in previous assessments. This is based on principles including analysis and alteration of contextual events and motivating factors, stimulus-consequence strategies and replacement behavior and monitoring of outcomes. Goals of treatment may include reduction of repetitive and aberrant behavior, and improved communication and social functioning. Adaptive behavior skill tasks are often broken down into small, measurable units, and each skill is practiced repeatedly until the individual masters it. Adaptive behavior treatment may occur in multiple sites and social settings (e.g., controlled treatment programs with individual alone or in a groups setting, home, or other natural environment). All ABA services are considered short term services whose objectives are to provide changes in patterns of interactions, daily activities and lifestyle including provider family/staff/caregivers skills to teach the individuals supported adaptive skills and skills to more appropriately address problem behaviors. The development of skills in the individual and in the family/staff/caregivers is a key component to these services. In addition it is the essential that the strategies

developed are adapted to more typical types of support strategies so that the treatment plan called the BSP is replaced with these more typical strategies as the service is successful. This treatment is further composed of the following elements: Adaptive Behavior Treatment by Protocol by Technician: is administered by a single technician or LaBA under the direction (on-site or off-site) of the QHCP by adhering to the protocols that have been designed by the QHCP. This service is delivered to the individual alone or while attending a group session. This includes skill training delivered to an individual who, for example, has poor emotional responses (e.g., rage with foul language and screaming) to deviation in rigid routines. The technician introduces small, incremental changes to the individual's expected routine along one or more stimulus dimension(s), and a reinforce is delivered each time the individual appropriately tolerates a given stimulus change until the individual tolerates typical variations in daily activities without poor emotional response. The QHCP directs the treatment by designing the overall sequence of stimulus and response fading procedures, analyzing the technician-recorded progress data to assist the technician in adhering to the protocol, and judging whether the use of the protocol is producing adequate progress. Adaptive Behavior Treatment with Protocol Modification: Unlike the Adaptive Behavior Treatment by Protocol by Technician, Adaptive Behavior Treatment with Protocol Modification is administered by a QHCP or LaBA who is face-to-face with a single individual. The service may include demonstration of the new or modified protocol to a technician, guardian(s), and/or caregiver. For example, Adaptive Behavior Treatment with Protocol Modification will include treatment services provided to a teenager who is recently placed with a foster family for the first time and is experiencing a regression of the behavioral targets which were successfully met the group-home setting related to the individual's atypical sleeping patterns. The clinical social worker modifies the past protocol targeted for desired results to incorporate changes in the context and environment. A modified treatment protocol is administered by the QHCP to demonstrate to the new caregiver how to apply the protocol(s) to facilitate the desired sleeping patterns to prevent sleep deprivation. Exposure Adaptive Behavior Treatment with Protocol Modification describes services provided to individuals with one or more specific severe destructive behaviors (e.g., self-injurious behavior, aggression, property destruction), with direct supervision by a QHCP which requires two or more technicians face-to-face with the individual for safe treatment. Technicians elicit behavioral effects of exposing the individual to specific environmental conditions and treatments. Technicians record all occurrences of targeted behaviors. The QHCP reviews and analyzes data and refines the therapy using single-case designs; ineffective components are modified or replaced until discharge goals are achieved (e.g., reducing destructive behaviors by at least 90%, generalizing the treatment effects across caregivers and settings, or maintaining the treatment effects over time). The treatment is conducted in a structured, safe environment. Precautions may include environmental modifications and/or protective equipment for the safety of the individual or the technicians. Often these services are provided in intensive out-patient, day treatment, or inpatient facilities, depending on the dangerousness of the behavior. Family Adaptive Behavior Treatment Guidance: Family/guardian/caregiver adaptive behavior treatment guidance is administered by a QHCP or LaBA face-to-face with family/guardian(s)/caregiver(s) and involves teaching family/guardian(s)/caregiver(s) to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits. Adaptive Behavior Treatment Social Skills Group: administered by a QHCP or LaBA face-to-face with multiple individuals, focusing on social skills training and identifying and targeting individual patient social deficits and problem behaviors. The QHCP or LaBA monitors the needs of individuals and adjusts the therapeutic techniques during the group, as needed. Services to increase target social skills may include modeling, rehearsing, corrective feedback, and homework assignments. In contrast to adaptive behavior treatment by protocol techniques, adjustments are made in real time rather than for a subsequent services. For individuals hospitalized, ABA may be provided to assist with supports, supervision, communication, and any other supports that the hospital is unable to provide. The services will: be identified in an individual's person-centered service plan; provided to meet needs of the individual that are not met through the provision of hospital services; not substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and be designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

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

Behavior Identification Assessment: A unit is 15 minutes. Limited to 8 units per year.

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

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

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

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

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

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

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

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

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

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

Family Adaptive Behavior Treatment Guidance, 15 minute unit: 40 units per month. In addition, no more than 8 family members/guardians/caregivers can be present for a unit to be billed. This service can be concurrent to any of the other treatment services.

Adaptive Behavior Treatment Social Skills Group, 15 minute unit: limited to 6 units per day, 30 units per week and 60 units per month. In addition, no more than 8 individuals can be present for a unit to be billed. This service can be concurrent to any of the other treatment services.

The services under the Partnership for Hope Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT but consistent with waiver objectives of avoiding institutionalization. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Applied Behavior Analysis (ABA)

Provider Category:

Agency

Provider Type:

Qualified Health Care Professional (QHCP)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Registration as Registered Behavior Technician with the Behavior Analyst Certification Board

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Initially and at contract renewal

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Applied Behavior Analysis (ABA)

Provider Category:

Individual

Provider Type:

Qualified Health Care Professional (QHCP)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Registration as Registered Behavior Technician with the Behavior Analyst Certification Board

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Initially and at contract renewal

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

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

Service Definition *(Scope):*

"Assistive technology" means a device, product system, or engineered solution whether acquired commercially, modified, or customized that addresses an individual's needs and outcomes identified in his or her individual service plan. The service is for the direct benefit of the individual in maintaining or improving independence, functional capabilities, vocational skills, or community involvement. Remote monitoring will assist the individual to fully integrate into the community, participate in community activities, and avoid isolation.

The individual's person-centered planning team will ensure that the individual understands the use of technology, the individual/family has information needed in order to make an informed choice/consent about remote monitoring versus an in-person support staff service, and that he/she understands privacy protections as documented in the approved ISP. The Support Coordinator and providers will share responsibility for monitoring privacy concerns. The ISP documents all back-up support plans based on the individual's needs. The ISP will document who is responsible for the monitoring activity and if they are on-site or off-site.

Remote supports promotes individuals building self-determination, self-reliance, independence and confidence which decreases their reliance on paid staff for activities in the home and community.

Assistive technology must include at least one of the following components :
(a) "Assistive technology consultation" means an evaluation of the assistive technology needs of an individual, including a functional evaluation of technologies available to address the individual's assessed needs and support the individual to achieve outcomes identified in his or her individual service plan.
(b) "Assistive technology equipment " means the cost of leasing, purchasing, warranty at purchase or otherwise providing for the acquisition of equipment and may include engineering, designing, fitting, customizing, or otherwise adapting the equipment to meet an individual's specific needs. Assistive technology equipment may include Personal Emergency Response Systems (PERS), Mobile Emergency Response Systems (MERS), Medication Reminder Systems (MRS) and equipment used for remote support such as motion sensing system, radio frequency identification, live video feed, live audio feed, or web-based monitoring. Assistive technology cannot be accessed to purchase video monitors or cameras to be placed in bedrooms and bathrooms. Remote monitoring and placement of cameras in bedrooms and bathrooms is not allowed.

(c) "Assistive technology service delivery" means monthly implementation of service and monitoring of the technology equipment and individual as necessary. Monitoring may include the response center for PERS, MERS, or remote support.

(d) "Assistive technology support" is intended for education and training beyond that included in initial installation/training and routine service delivery questions and implementation that aids an individual in the use of assistive technology equipment as well as training for the individual's family members, guardians, staff, or other persons who provide natural supports or paid services, employ the individual, or who are otherwise substantially involved in activities being supported by the assistive technology equipment. Assistive technology support may include, when necessary, coordination with complementary therapies or interventions and adjustments to existing assistive technology to ensure its ongoing effectiveness.

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

Assistive technology equipment does not include items otherwise available as environmental accessibility adaptations or specialized medical equipment and supplies.

Assistive technology consultation is limited to one per year. An exception may be extended if the participant is pursuing a new or additional type of technology in the same year.

Assistive technology support is limited to 40 hours per year.

The costs of all components of Assistive Technology equipment shall not exceed $9,000 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.

An individual cannot receive the Mobile Emergency Response Systems (MERS) and the Personal Emergency Response Systems (PERS) service at the same time.

The services under the Comprehensive Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT.
Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Technology Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Assistive Technology Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The consultation component may be provided by a person with a Missouri license in occupational therapy or physical therapy or speech-language pathology or an Assistive technology professional certification issued by the "Rehabilitation Engineering and Assistive Technology Society of North America" or a Bachelors degree and a certificate from a nationally recognized assistive technology assessment curriculum or a Bachelors degree considered a specific technology expert as employed by the technology specific provider for at least one year .

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

DMH Contract.

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

Remote monitoring will meet HIPAA requirements and the methodology will be accepted by the state's HIPAA compliance officer.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Benefits Planning

HCBS Taxonomy:

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

Service Definition *(Scope):*

Benefits Planning is a service designed to inform an individual about competitive integrated employment and assist them to assess if it will result in increased economic self-sufficiency and/or net financial benefit through the use of various work incentives. This service provides information to the participant regarding the full array of available work incentives for essential benefit programs including Supplemental Security Income, SSDI, Medicaid, Medicare, housing subsidies, food stamps, ABLE accounts, etc.

The service also will provide information, education, consultation and technical assistance to the individual regarding:

- Income reporting requirements for public benefit programs, including the Social Security Administration
- Formalized development of Plans for Achieving Self Sufficiency (PASS), Property Essential to Self-Support (PESS)
- Assistance with utilization of social security work incentives
- Coordination of Social Security and Medicaid work incentives and benefits support
- Individual benefit verification, consultation, education and ongoing analysis/planning.

Benefits Planning can be provided to individuals considering or seeking competitive integrated employment, career advancement or to individuals who need financial problem-solving assistance to maintain competitive integrated employment.
This service may include activity on behalf of the individual to assist in provision of the benefits planning service. The service can be provided in person or virtually based on the individual's informed choice.
Benefits Planning may only be provided if a Certified Work Incentives Counselor through a Missouri-based Social Security Supported Work Incentives Planning and Assistance (WIPA) program were sought and it is documented by the Support Coordinator that such services were not available, accessible or applicable due to either ineligibility or because of wait lists that would result in services not being available within 30 calendar days (this is only required once per year; i.e., it must be repeated if Benefits Planning is needed in a subsequent year).

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

Benefits Planning services are limited to a maximum of 60 units per annual support plan for any combination of initial benefits planning, supplementary benefits planning when an individual is evaluating a job offer/promotion or a self-employment opportunity, or problem-solving assistance to maintain competitive integrated employment.

Additional units may be approved by the Division's Regional Director or designee in exceptional circumstances.

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	**Individualized Supported Living**
Agency	**Day Habilitation Provider**
Agency	**Group Home**
Individual	**Certified Community Work Incentive Counselor; Community Partner Work Incentives Counselor or a credentialed Work Incentive Practitioner**
Agency	**Employment Service Provider**

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits Planning

Provider Category:

Agency

Provider Type:

Individualized Supported Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Staff (direct or contracted) who will work directly with the participant to provide Benefits Planning services shall maintain current national certification as a Certified Community Work Incentive Counselor; Community Partner Work Incentives Counselor or a credentialed Work Incentive Practitioner.

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval and at contract renewal

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits Planning

Provider Category:

Agency

Provider Type:

Day Habilitation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Staff (direct or contracted) who will work directly with the participant to provide Benefits Planning services shall maintain current national certification as a Certified Community Work Incentive Counselor; Community Partner Work Incentives Counselor or a credentialed Work Incentive Practitioner.

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval and at contract renewal

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits Planning

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Staff (direct or contracted) who will work directly with the participant to provide Benefits Planning services shall maintain current national certification as a Certified Community Work Incentive Counselor; Community Partner Work Incentives Counselor or a credentialed Work Incentive Practitioner.

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval and at contract renewal

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits Planning

Provider Category:
Individual
Provider Type:

Certified Community Work Incentive Counselor; Community Partner Work Incentives Counselor or a credentialed Work Incentive Practitioner

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Staff (direct or contracted) who will work directly with the participant to provide Benefits Planning services shall maintain current national certification as a Certified Community Work Incentive Counselor; Community Partner Work Incentives Counselor or a credentialed Work Incentive Practitioner.

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval and at contract renewal

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits Planning

Provider Category:
Agency
Provider Type:

Employment Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Staff (direct or contracted) who will work directly with the participant to provide Benefits Planning services shall maintain current national certification as a Certified Community Work Incentive Counselor; Community Partner Work Incentives Counselor or a credentialed Work Incentive Practitioner.

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval and at contract renewal

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Career Planning

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03030 career planning
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Career Planning is a comprehensive individualized service which supports a participant with vocational discovery, identification of career themes (pathways) and development of a plan to achieve competitive integrated or self-employment goals. The outcome of this service is documentation of the participant's stated career objective and a completed career plan/discovery profile used to guide ongoing individual employment support needs.

Career Planning activities may include but are not limited to the coordination and delivery of:
- Home and neighborhood observations
- Job exploration
- Job shadowing
- Informational interviewing
- Work specific review of assistive technology
- Assessment of interests and skills
- Labor market research
- Vocational and job related discovery on asset development

Providers of this service may coordinate, evaluate and communicate not only with the individual but, also with their caregivers, support team, employers, teachers and others who can assist with discovering an individual's skills, abilities, interests, preferences, conditions and needs. This support and evaluation should be provided in the presence of the individual to the maximum extent possible and should be conducted in the community to the maximum extent possible; but, completion of activities in the home or without the presence of the individual is not precluded.

If an individual is employed, career planning may be used to explore other ongoing competitive employment career objectives which are consistent with the person's skills and interests or explore advancement opportunities in his or her chosen career.

Career Planning should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals.

Career Planning furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 and its amendments or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Therefore, the case record for any individual receiving this service must document the individual is not eligible for, unable to access, exhausted services or otherwise inapplicable for the aforementioned programs as outlined in an interagency MOU between Vocational Rehabilitation and the Division of DD.

Transportation costs for the implementation of Career Planning services are included in the unit rate.

Personal care assistance may be provided to support an individual while receiving this service, but may not comprise the entirety of the service.

Outcomes expected for this service are as follows:
An identified career path and profile which includes the individual's needs, interests, strengths, natural supports and characteristics of potential work environments and a plan specifying actions necessary to achieve the individual's career goals.

Service Documentation:
Providers of Career Planning must maintain an individualized plan and detailed record of activities by unit of service.

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

Career Planning is intended to be time-limited. Services should be authorized through person centered employment planning based upon individualized assessed need not to exceed 240 units of services within annual support plan. Additional units may be approved by the Division's Regional Director or designee in exceptional circumstances.

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	Employment Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Career Planning

Provider Category:

Agency

Provider Type:

Employment Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010 certification; CARF; CQL accreditation

Other Standard *(specify):*

DMH contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Networking

HCBS Taxonomy:

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

Service Definition *(Scope):*

Community Networking, formerly known as Community Integration coordinates and provides support for valued and active participation in integrated activities that build on the person's interests, preferences, gifts, and strengths while reflecting the person's goals with regard to community involvement and membership.

Community Networking services are designed to increase an individual's connection to and engagement in formal and informal community supports. Services are designed to develop flexible, sustainable, and supportive community resources and relationships. Individuals are introduced to community resources and supports that are available in their area and supported to develop skills that will facilitate integration into their community. Outcomes for this service include positive relationships, valued community roles, and involvement in preferred community activities/organizations/groups/projects/other resources. Community Networking outcomes are developed through a person centered planning process and provided in accordance with the individual support plan.

Expectations are for paid supports to be decreased and transitioned to natural supports over time when possible.

Community Networking is not intended or designed to be used in employment settings.

Personal Assistant services may be a component of Community Networking as necessary for the individual to participate in the service but may not comprise the entirety of the service.

Transportation costs related to the provision of this service in the community are included in the service rate.

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

This service is limited to 432 units (108 hours) per month.

Individuals who receive Group Home, Individualized Supported Living, or Shared Living may not receive this service.

Group Community Networking may not exceed 4 individuals per staff person.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Networking

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Networking

Provider Category:

Agency

Provider Type:

Community Networking

Provider Qualifications

License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010 certification; CARF accredited Community Networking, CQL, or The Joint Commission

Other Standard *(specify):*

DMH Contract
Direct contact staff must have:
A high school diploma or its equivalent, or Level 2 Direct Support Professional (DSP) trained within a year of employment; training in CPR and First Aid;
Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administration training must be updated every two years with successful completion.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval and every three years;

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Specialist

HCBS Taxonomy:

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

Service Definition *(Scope):*

A community specialist is used when specialized supports are needed to assist the individual in achieving outcomes in the service plan.

Community specialist services includes professional observation and assessment, individualized program design and implementation and consultation with caregivers. This service may also, at the choice of the individual designated representative, include advocating for the individual, and assisting the individual in locating and accessing services and supports within their field of expertise. CS is a direct service which may require higher level of skillset and training that assist the individual in achieving their outcomes. The CS performs the implementation strategies of the outcome through direct instruction. CS staff may be part of the Person-Centered Planning process that identifies the individual's needs and desires; however, does not authorize the service nor monitors the progress of the CS service.

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

This service shall not duplicate other waiver services including but not limited to: ABA or Personal Assistant services.

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

Community specialist, a direct waiver service, differs in service definition and in limitations of amount and scope from State plan TCM for person with DD. In the latter, there are waiver administrative functions performed by a support coordinator through state plan TCM that fall outside the scope of community specialist, such as LOC determination, free choice of waiver and provider, due process and right to appeal. Additionally, MO Division of DD support coordinators facilitate services and supports, authorized in the service plan, through the regional office UR and authorization process.

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

Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Qualified Community Specialist
Agency	Qualified Community Specialist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Specialist

Provider Category:

Individual

Provider Type:

Qualified Community Specialist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Specialist

Provider Category:

Agency

Provider Type:

Qualified Community Specialist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Transition services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence.

Provider operated living arrangements shall include any provider-owned residential setting where MO HealthNet reimbursement is available, including the following:
• Intermediate Care Facilities for Individuals with Intellectual Disabilities
• Nursing Facilities
• Residential Care Facilities
• Assisted Living Facilities
• DD Waiver Group Homes

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:
• Essential household furnishings and moving expenses required to occupy and use a community domicile;
• Security deposits that are required to obtain a lease on an apartment or home that does not constitute paying for housing rent;
• Utility set-up fees or deposits for utility or service access (e.g. telephone, internet service set-up, water, electricity, heating, trash removal);
• Health and safety assurances, such as pest eradication, allergen control (only be rendered when the allergen control addresses the individual's disability who demonstrates a need for allergen control), or one-time cleaning prior to occupancy.

Essential furnishings include items for an individual to establish his or her basic living arrangement, such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items. Community transition services shall not include monthly rental or mortgage expenses; food; regular utility charges; household appliances; or items that are intended for purely diversional or recreational purposes such as televisions, TV service or media players.

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

This service is limited to persons who transition from a congregate living to a living arrangement in a private residence. The services must be necessary for the person to move from an institution and the need must be identified in the person's plan. Total transition services are limited to $3,000 per participant over their lifetime in the process of moving from a congregate living setting to the community. A unit of service is one item or expense.

Community Transition services may not be used to pay for furnishing living arrangements that are provider operated living arrangements where the provision of these items and services are inherent to the service they are already providing.

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	Division of DD Regional Office
Individual	Individual Contractor
Agency	Agency Contractor
Agency	Individualized Supported Living Provider
Agency	Group Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Division of DD Regional Office

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meets Organized Health Care Delivery System (OHCDS) designation

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office; DMH Central Office Contract Unit

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Individual

Provider Type:

Individual Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DMH Contract, Applicable business license for service provided

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Agency Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Registered with Missouri Secretary of State in good standing; DMH Contract; Applicable business license for service provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Individualized Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010 certification; CARF; CQL; or Joint Commission accreditation

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010 certification; CARF; CQL; or Joint commission accreditation

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations-Home/Vehicle Modification

HCBS Taxonomy:

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

14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations

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

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

Service Definition *(Scope):*

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

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

The following vehicle adaptations are specifically excluded in the waiver: adaptations or improvements to the vehicle that are of a general utility, and are not of direct medical or remedial benefit to the individual; purchase or lease of a vehicle; and regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modification. However, the service can be used toward the purchase of the existing adaptations in a vehicle. In these instances, dealership/vendor must be paid directly by the state. The individual will not receive any Medicaid funding to make the purchase. The dealership/vendor must provide an invoice/purchase order that only includes the vehicle adaptions and not the vehicle. The price of the adaption is comparable to market value and not include any labor cost.

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

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

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

Costs are limited to ~~$20,000 biennially~~~~$7,500 per year~~, per individual. The biennial~~annual~~ limit corresponds to the annual support plan. ~~waiver year~~, ~~which begins July 1 and ends June 30 each year~~.

~~An exception may be approved by the Regional Director and DD Deputy Assistant Director with a maximum limit of $10,000 per waiver year, per individual.~~

A single job exceeding $10,000.00 requires approval by the individual and/or their guardian and an Occupational or Physical Therapist or Division employee or contractor approved by the Division to review the work prior to service billing.

The services under the Partnership for Hope Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT.

Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Contractor
Individual	Contractor

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Offices

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must have applicable business license and meet applicable building codes; DMH Contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Offices

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family Peer Support

HCBS Taxonomy:

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

Service Definition *(Scope):*

The Family Peer Support service is an array of formal and informal services and supports provided by a Family Support Partner (FSP) to families who have a family member with an intellectual/ developmental disability (I/DD). Family is defined as the primary care giving unit and is inclusive of the wide diversity of caregivers in our culture. For the purpose of the Family Peer Support service, family is further defined as the persons who live with or provide care to a person with I/DD receiving services through a waiver and may include a parent, spouse, sibling, children, relatives, grandparents, foster parents, or others with significant attachment to the individual.

A FSP provides nonclinical family peer support by sharing valuable personal knowledge based experience in supporting and providing care to a family member with an I/DD. This service may also include identifying and developing formal and informal supports, instilling confidence, assisting in the development of individual and family goals, serving as an advocate, mentor, or facilitator for resolution of issues and skills necessary to enhance and improve the health and well-being of the individual and their family unit and to help reduce caregiver stress and isolation. The FSP service builds on a family's strengths, buffers risk while building protective factors, and promotes optimal outcomes. The FSP service supports the parent/family and enhances their skills so they can effectively understand and contribute to planning processes and access services that will better promote positive functioning, which results in their family member's ability to live successfully in their home and community. The FSP assists families by providing information and training as needed to support the family to increase their ability to provide a safe and supportive environment in the home and community for their family member.

Developing positive family rapport is critical to the effectiveness of this service and, therefore, personal face-to-face visits in a variety of settings may be necessary. Face-to-face support may be supplemented by phone or electronic correspondence.

FSP services may be provided individually or in a group setting.

FSP services provided must include communication and coordination with the family and/or legal guardian and may be provided concurrent with the development of the family member's ISP. Coordination with other systems should occur as needed to achieve the family's goals.

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

Services are episodic, conditional on life events and existing circumstances of the family and not intended to be long-term and ongoing. As families develop resiliency skills, services should be faded. A FSP shall not deliver this service within their immediate or extended family.

Units of service are 15 minute increments. A maximum of 640 units per family can be authorized on an annual basis. Additional units must be pre-authorized by the Division's Regional Director or designee.
This service shall not duplicate other waiver or state plan services including, but not limited to: TCM, Community Specialist, Support Broker, or Respite Care.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Family Support Organization

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Peer Support

Provider Category:

Agency

Provider Type:

Family Support Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DMH Contract; agency employs an individual with the following qualifications:
- be a parent or family member
- Have at least five years of lived experience supporting a family member with I/DD. Lived experience must be relevant to the purpose of this service and will include a personal history of being actively involved in providing care and support for the individual and their family members.
  - Be at least 18 years of age and have a high school diploma or its equivalent, or Level 2 Direct Support Professional (DSP) trained within a year of employment.
- FSPs without diplomas or GEDs may be employed for up to one year while they work to attain the requirement. The provider must document the staff's enrollment in school or GED courses within 60 days from the date of employment.
- Pass all required criminal and background checks.
- Successfully attend and complete orientation, DMH approved curriculum/training(s), and certification exam related to position.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Individual Directed Goods and Services (IDS) refers to a service, support, or good that enhances the individuals' opportunities to achieve outcomes related to full membership in the community.
Each service, support or good selected must meet each of the following eight criteria:

1. The service, support or good is designed to meet the individual's safety needs, community membership and also advances the desired outcomes in his/her Individual Support Plan (ISP);
2. The service, support or good must increase independence or substitute for human assistance;
3. The service, support or good must reduce the need for another Medicaid waiver service;
4. The service, support or good must have documented outcomes in the ISP;
5. The service, support or good is not prohibited by Federal and State statutes and regulations;
6. The service, support or good is not available through another source and the person does not have the funds to purchase it;
7. The service, support or good will be acquired based upon anticipated use and most cost-effective method (rental, lease, and/or purchase); and
8. The service, support or good must not be experimental or prohibited.

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

Costs are limited to $3,000 per annual support plan year, per individual. The annual support plan year corresponds to the person-centered service plan year.

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	Vendor Fiscal/Employer Agent Fiscal Management Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:

Agency

Provider Type:

Vendor Fiscal/Employer Agent Fiscal Management Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Vendor Fiscal/Employer Agent Financial Management Services must comply with all requirements specified in the current contract between the Vendor Fiscal/Employer Agent and the Missouri Department of Mental Health

Verification of Provider Qualifications

Entity Responsible for Verification:

Missouri Department of Mental Health, Division of Developmental Disabilities

Frequency of Verification:

Frequency as specified in the current contract between the Vendor Fiscal/Employer Agent and the Missouri Department of Mental Health.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individualized Skill Development

HCBS Taxonomy:

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

Service Definition *(Scope):*

Individualized Skill Development (ISD) are individualized supports, delivered in a personalized manner, to support individuals who live in their own or family homes with acquiring, building, or maintaining complex skills necessary to maximize their personal independence. Teaching methods are individualized to what the participant wants to accomplish, learn and/or change based on the identified skill as developed in the person-centered planning process and provided in accordance with the individual support plan to achieve identified outcomes.
Complex skills development include but is not limited to domestic and home maintenance, budgeting and money management, and using public transportation. Transportation costs related to the provision of this service in the community are included in the service rate.
This is an episodic support of a clearly identified skill as developed through a person centered planning process and provided in accordance with the individual support plan the provider must document monthly progress toward achieving each skill identified in the individual support plan which shall include an annual review of progress towards the individual's independent living goals.

Personal Assistant services may be a component of Individualized Skill Development as necessary for the individual to participate in the service but may not comprise the entirety of the service.

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

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

Individuals who receive Group Home, Individualized Supported Living, or Shared Living may not receive this service

This service is limited to 348 units (87 hours) a month.

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

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

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

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individualized Skill Development

Provider Category:
Agency
Provider Type:

Day Habilitation
Provider Qualifications
License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010; CARF; CQL; or Joint Commission
Other Standard *(specify):*

DMH Contract;
Direct contact staff must have:
A high school diploma or its equivalent, or Level 2 Direct Support Professional (DSP) trained within a year of employment; training in CPR and First Aid; state credentialing in skill development. Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administrationtraining must be updated every two years with successful completion.

Verification of Provider Qualifications
Entity Responsible for Verification:

Regional Office
Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individualized Skill Development

Provider Category:
Agency
Provider Type:

Individualized Skill Development
Provider Qualifications
License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010; CARF accredited, CQL, or The Joint Commission

Other Standard *(specify):*

DMH Contract; ;
Direct contact staff must have:
A high school diploma or its equivalent, or Level 2 Direct Support Professional (DSP) trained within a year of employment training in CPR and First Aid; state credentialing in skill development. Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administrationtraining must be updated every two years with successful completion.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Job Development

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Job Development is a support service to facilitate competitive work in an individual integrated work setting. The service must be identified in the individual's service plan based upon an individualized assessed need which promotes the greatest degree of integration, independence and autonomy.

Job Development services are the supports to individuals who, because of the disabilities, will need assistance with obtaining individual competitive or customized employment in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is the acceptance of an employment offer in a job that meets personal and career goals.

Job Development services may include:
- Application completion assistance with the individual,
- Job interviewing activities with the individual,
- Completion of job analysis and/or task analysis with or without the presence of the individual based upon individualized need,
- Negotiation with prospective employers and education of prospective employers of their role in promoting full inclusion with or without the presence of the individual based upon individualized need.
- Consultation with the prospective employer on the use of assistive technology to promote greater autonomy and independence in the potential workplace,
- Consultation and negotiation of work hours, wages and earnings.

Additional Information about Job Development services:
Job Development services must be provided in a manner that promotes integration into the workplace and interaction between individuals and people without disabilities in those workplaces while maintaining the individual's rights of dignity, privacy and respect.
This service and support should be designed to support a successful employment outcome consistent with the individual's assessed goals, needs, interests and preferences. An individual's autonomy and independence to perform employment with the least amount of restrictions must be supported through the person centered planning process.

Job Development should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual.

Job Development furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 and its amendments or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Therefore, the case record for any individual receiving this service must document the individual is not eligible for, unable to access, exhausted services or otherwise inapplicable for the aforementioned programs as outlined in an interagency MOU between Vocational Rehabilitation and the Division of DD.

Personal care assistance may be provided to support an individual while receiving this service, but may not comprise the entirety of the service.

Transportation costs are included in the implementation of Job Development service.

FFP is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; or
2) Payments that are passed through to users of community employment programs.

Outcomes expected for this service are as follows:
A job retention plan to include job title, wages, projected average number of hours to be worked weekly and recommended implementation strategies for paid/natural supports regarding unmet needs (i.e. personal assistance, transportation, skill acquisition, employment onboarding, workplace integration, etc.).

Service Documentation:
Providers of Job Development must maintain an individualized plan and detailed record of activities by unit of service.

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

Job Development is intended to be time-limited. Services should be authorized through person centered employment planning based upon individualized assessed need not to exceed 240 units of services within an annual support plan. Additional units may be approved by the Division's Regional Director or designee in exceptional circumstances.

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	Employment Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Job Development

Provider Category:

Agency

Provider Type:

Employment Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

9 CSR 45-5.010 certification; CARF, CQL accreditation

Other Standard *(specify):*

DMH contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Occupational Therapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

Occupational therapy (OT) requires prescription by a physician and evaluation by a certified OT. The service includes evaluation, plan development, direct therapy, consultation and training of caretakers and others who work with the individual. A certified occupational therapeutic assistant (COTA) may provide direct therapy services under the supervision of an OT. It may also include therapeutic activities carried out by others under the direction of an OT or COTA. Examples are using adaptive equipment, proper positioning and therapeutic exercises in a variety of settings.

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

The services under the Partnership for Hope are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
The services under the Community Support Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT

Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

This service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Agency	Agency employing licensed Occupational Therapists and may also employ registered COTA's supervised by licensed Occupational Therapists

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified per RSMo 1990 334.735-334.746 as Occupational Therapist by AOTA or registered as a COTA

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Agency employing licensed Occupational Therapists and may also employ registered COTA's supervised by licensed Occupational Therapists

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified per RSMo 1990 334.735-334.746 as Occupational Therapist by AOTA or registered as a COTA

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Physical Therapy

HCBS Taxonomy:

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

Service Definition (Scope):

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

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

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

A unit of service is 1/4 hour.

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

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

The services under the Partnership for Hope are limited to additional services not otherwise covered under the state plan, including EPSDT.

Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

This service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physical Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:
Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Licensed per RSMo 1990 334.530--334.625

Certificate *(specify):*

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: 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:

Professional Assessment and Monitoring

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11010 health monitoring
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Professional Assessment and Monitoring (PAM) is intended to promote and support an optimal level of health and well-being. A prescribing practitioner must prescribe an identified need for the PAM service. PAM is a consultative service by a licensed health care professional that may be utilized to assess, examine, evaluate, and/or treat an individual's identified condition(s) or healthcare needs and planning and may include instruction and training when identified as needed for the care of an individual. PAM services maintain, restore and / or improve an individual's functional status. PAM may include ancillary, management and / or instructional strategies.

PAM providers are to coordinate and communicate with the individual, their caregivers and the support team. All changes in health status are to be communicated to the physician and the support coordinator. Written reports of the visit will be provided to the support coordinator. All services must be documented in the individual record.

Any changes in health status are to be reported to the physician and support coordinator as needed. Written reports of the visit are required to be sent to the support coordinator. This service may be provided by a RN, or a LPN under the supervision of a RN, or a licensed dietitian to the extent allowed by their respective scope of practice in the State of Missouri.

This service must not supplant Medicaid State plan services or Medicare services for which an individual is eligible. Excluded services include Diabetes Self-Management Training available under the state plan and medical nutrition therapy services prescribed by a physician for Medicare eligibles who have diabetes or renal diseases. PAM is not continuous care.

PAM service providers must have a valid DMH contract and/or provide services through an OHCDS for the provision of PAM services.

Service Documentation:
Providers of PAM must maintain an individualized plan of treatment and detailed record of intervention activities by unit of service.

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

Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

This service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The contractor shall not be the consumer's spouse, a parent of a minor child (under age 18), nor a legal guardian.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Professional Nurse or Dietician
Agency	Professional Nurse or Dietician

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Assessment and Monitoring

Provider Category:

Individual

Provider Type:

Professional Nurse or Dietician

Provider Qualifications

License *(specify):*

Licensed per RsMo Chapter 335., 20 CSR 2200-4.020 in Missouri as a RN, LPN, or licensed per RsMo 324.200-324.4.225, 20 CSR 2115-2.020 Dietitian

Certificate *(specify):*

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to initial contract and renewal; as needed based on service monitoring concerns

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Professional Assessment and Monitoring

Provider Category:

Agency

Provider Type:

Professional Nurse or Dietician

Provider Qualifications

License *(specify):*

Licensed per RsMo Chapter 335., 20 CSR 2200-4.020 in Missouri as a RN, LPN, or licensed per RsMo 324.200-324.4.225, 20 CSR 2115-2.020 Dietitian

Certificate *(specify):*

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to initial contract and renewal; as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies (Adaptive Equipment)

HCBS Taxonomy:

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

Service Definition *(Scope):*

Specialized medical equipment and supplies includes devices, controls, or appliances, specified in the support plan, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, durable and non-durable medical equipment and supplies, and equipment repairs when the equipment, supplies and repairs are not covered under the Medicaid State Durable Medical Equipment (DME) plan. Includes incontinence supplies.

Items reimbursed with waiver funds, shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

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

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

Other specialized equipment, supplies and equipment repair needs for the eligible person that can be met through state plan, including EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Further, this waiver service may also be authorized for items/repairs not covered under state plan and falls within the waiver service definition described above.
The services under the Partnership for Hope are limited to additional services not otherwise covered under the state plan, including EPSDT.

Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

This service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Equipment & Supply

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies (Adaptive Equipment)

Provider Category:

Agency

Provider Type:

Medical Equipment & Supply

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Registered and in good standing with Missouri Secretary of State; DMH Contract; The provider must be enrolled with MO HealthNet as a state plan DME Provider or currently possess a DMH contract to provide any other DD waiver service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Speech Therapy

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11100 speech, hearing, and language therapy

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Speech Therapy (ST)is for individuals who have speech, language or hearing impairments. Services may be provided by a licensed speech language therapist or by a provisionally licensed speech therapist working with supervision from a licensed speech language therapist. The individual's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. The need for services must be identified in the support plan and prescribed by a physician. ST provides treatment for delayed speech, stuttering, spastic speech, aphasic disorders, and hearing disabilities requiring specialized auditory training, lip reading, signing or use of a hearing aid.

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

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

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

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

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

Speech therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be utilized before waiver services can be provided. ST services authorized through the waiver shall not duplicate state plan services. Children have access to EPSDT services.

The services under the Partnership for Hope Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT.

Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

This service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Speech Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech Therapy

Provider Category:
Individual
Provider Type:

Licensed Speech Therapist
Provider Qualifications
License *(specify):*

Licensed per RSMo 1990 345.050
Certificate *(specify):*

Provisionally licensed per RSMo 1998 345.022, employed & supervised by licensed speech therapist
Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional office

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: 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:

Temporary Residential Service

HCBS Taxonomy:

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

Service Definition *(Scope):*

Temporary Residential Service is care provided in the individual's place of residence, the community or outside the home in a licensed, accredited or certified waiver residential facility, ICF/ID or State Habilitation Center, stand-alone facility or Shared Living Host Home Relief/Relief Home by trained and qualified personnel by trained and qualified personnel The need for this service has to be an identified need through the planning process which would include the individual, guardian if applicable, the primary caregiver, other family members, support coordinator, and any other parties the individual requests.

This service is not delivered in lieu of day care for children nor does it take the place of day services programming for adults. A unit of service is 15 minutes, when provided in increments less than 24 hours, or one day (24 hours).

Temporary Residential Service is provided to individuals unable to care for themselves, on a short-term basis. This service is also furnished because of the absence or need for relief of those persons who normally care for the participant. It is a residential support of providing temporary care, assistance and supervision directly to eligible persons and is not intended to be permanent placement. FFP is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Shared Living Host Home/Relief Home is a component of the Shared Living service. Shared Living can be provided in the home of the care giver (Host Home Services) or in the individual's home (Companion Services). Shared Living settings are contained in the STP, and any Host Home/Relief Home setting crosswalks to the Shared Living setting.

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

Temporary Residential service is a service used on a short-term basis because of the absence or need for relief of those persons who normally provide care for the individual. Temporary Residential service is limited to no more than 60 days annually, unless a written exception is granted from the regional office director or designee. This limit may be exceeded on an individual basis when necessary to protect the health and welfare of a waiver participant subject to the approval of both the county board and regional directors. The 60 days may be consecutive, unless the service is provided in an ICF/ID or State Habilitation Center. Temporary Residential Service provided in an ICF/ID or State Habilitation Center cannot exceed 30 days. The total limit of out of home respite is 6 months. Any settings where individuals will be served for over 60 days must comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5). Temporary Residential Services are temporary and require a hard limit to the exception amount. This will not affect section 9817 of ARP.

A host home provider shall not provide Temporary Residential service if there is an individual currently residing in the home and receiving host home services. A host home provider may provide Temporary Residential service if there is not currently an individual residing in the home and receiving host home 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	Stand-alone Respite Facility
Agency	Shared Living Host Home/Relief Home
Agency	Group Home
Agency	State-operated ICF/ID

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Temporary Residential Service

Provider Category:

Agency

Provider Type:

Stand-alone Respite Facility

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified under 9 CSR 45-5.010-.060

Other Standard *(specify):*

Accredited through CARF, CQL, or Joint Commission.
DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval or renewal; service review every 3 years; as needed basis on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Temporary Residential Service

Provider Category:

Agency

Provider Type:

Shared Living Host Home/Relief Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified under 9 CSR 45-5.010-.060;

Other Standard *(specify):*

Accredited through CARF, CQL, or Joint Commission. DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Office

Frequency of Verification:

Prior to contract approval or renewal; service review every 3 years; as needed basis on service monitoring concerns.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Temporary Residential Service

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

9 CSR 40-1,2,4,5

Certificate *(specify):*

9 CSR 45-5.010; CARF; CQL or Joint Comission

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Offices

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Temporary Residential Service

Provider Category:

Agency

Provider Type:

State-operated ICF/ID

Provider Qualifications

License *(specify):*

Certificate *(specify):*

13 CSR 15-9.010

Other Standard *(specify):*

In good standing with DHSS.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHSS ICF/ID Unit;

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Transportation is reimbursable when necessary for an individual to access waiver and other community services, activities and resources specified by the service plan. Transportation under the waiver shall not supplant transportation provided to providers of medical services under the state plan as required by 42 CFR 431.53, nor shall it replace emergency medical transportation as defined at 42 CFR 440.170(a) and provided under the state plan. State plan transportation in Missouri is provided to medical services covered under the state plan, but not to waivered services, which are not covered under the state plan.

Regional offices must provide the transportation provider with information about any special needs of participants authorized for transportation services. A variety of modes of transportation may be provided, depending on the needs of the individual and availability of services. Alternatives to formal paid support will always be used whenever possible. A unit is one per month.

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

State plan transportation under this waiver is limited to medical services covered in the state plan. State plan transportation does not cover transporting persons to waiver services, which are not covered under the state plan.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transportation Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Transportation Agency

Provider Qualifications

License *(specify):*

RSMo., Chapter 302, Drivers & Commercial Licensing

Certificate *(specify):*

Other Standard *(specify):*

DMH Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional Offices

Frequency of Verification:

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

Appendix C: Participant Services

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

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

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

Check each that applies:

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

Division of DD Regional Offices (State Employees), and approved TCM Entities Employees.

Appendix C: Participant Services

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

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

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

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory

investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) Background screening is required for all provider staff and volunteers who have contact with consumers. Background screenings are required for volunteers who are recruited as part of an agency's formal volunteer program. It does not apply to natural supports who assist individuals as a friend would by providing assistance with shopping, transportation, recreation, etc. Background screenings are also required for members of the provider's household who have contact with residents or consumers, except for minor children. (RSMo 630.170),(Title 9 Code of State Regulations 10-5.190 and Department Operating Regulation 6.510).

(b) An inquiry must be made for all new employees and volunteers with the Missouri DHSS to determine whether the new employee or volunteer is on DSS or the DHSS disqualification list. An inquiry is also made with the DMH to determine whether the individual is on the DMH disqualification registry. A criminal background check with the Missouri State Highway Patrol is required. The criminal background check and inquiries are initiated prior to the employee or volunteer having contact with residents, clients, or patients. All new applicants for employment or volunteer positions involving contact with residents or clients must: 1) sign a consent form authorizing a criminal record review with the Missouri State Highway Patrol either directly through the patrol or through a private investigatory agency; 2) disclose his/her criminal history including any conviction or a plea of guilty to a misdemeanor or felony charges and any suspended imposition of sentence, any suspended execution of sentence, or any period of probation or parole; and 3) disclose if he/she is listed on the employee disqualification list of the DSS, DHSS, or DMH.

(c) Employers are responsible for requesting the background screenings. A single request is used and submitted to the state's Family Care Safety Registry (FCSR), operated by the DHSS. The FCSR has access to the criminal record system of the state Highway Patrol as well the abuse/neglect and employee disqualification lists/registries that are required. Employers responsible for requesting background screenings are any public or private residential facility, day program, or specialized service operated, licensed, certified, accredited, in possession of deemed status, or funded by the DMH or any mental health facility or mental health program in which people are admitted on a voluntary basis or are civilly detained. Pursuant to chapter 632 this background screen shall be done no later than two working days after hiring any person for a full-time, part-time, or temporary position that will have contact with clients, residents, or patients. The criminal history/background investigations are statewide.

(d) Each agency must develop policies and procedures regarding the implementation of this rule and the disposition of information provided by the criminal record review. Review of provider policies and procedures are part of a provider certification site visit per 9 CSR 10-5.1904

The DMH certification process and Division of DD Provider Relations review process all look for evidence that background investigations are completed as required. The DMH licensure/certification process occurs every 2 years and Division of DD Provider Relations review process occurs every 3 years and both look for evidence that background investigations are completed as required. The DMH certification process occurs every 2 years and Division of DD Provider Relations review process occurs every 3 years and both look for evidence that background investigations are completed as required.

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

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

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

(a) The DMH maintains the Disqualification Registry which is a list of individuals disqualified from working with consumers receiving services from the department. Statutory authority is contained in RSMo 630.170. The DHSS also maintains an employee disqualification list.
(b) All new applicants for employment or volunteer positions involving contact with participants are checked against the DMH's Disqualification Register and the DHSS' Disqualification List.

(c) Surveys for licensing and certifying community residential facilities and day programs ensure these providers have records to support staff and volunteers have been properly screened. The DMH certification and Provider Relations review a sampling of employees during their review cycles which focus on new hires since the last review to ensure providers have a system to obtain screenings within the regulation parameters and are evaluating the results accurately.
Local Regional Office QE staff or Department audit services staff review records while conducting other reviews or based on reports that screenings are not being completed.

(d) Employers are responsible for requesting the background screenings including criminal background check and inquiries, no later than two working days after hiring. A single request is used and submitted to the state's FCSR, operated by the DHSS. The FCSR has access to the criminal record system of the state Highway Patrol as well the abuse/neglect and employee disqualification lists/registries that are required. Thereafter, the employer is responsible for ensuring that staff are free of disqualifying felonies or adverse actions by the Department of Health and Senior Services and DMH. Licensure/Certification survey process reviews background screenings every 2 years as initiated by the provider which includes reviewing the employee's personnel record.

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

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

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

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

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

☐ **Self-directed**

☐ **Agency-operated**

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

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

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

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

Personal assistant services shall not be provided by an individual's spouse, if the individual is a minor (under age 18) by a parent, or legal guardian. Personal assistant services may otherwise be provided to a person by a member(s) of his or her family when the person is not opposed to the family member providing the service and the service to be provided does not primarily benefit the family unit, is not a household task family members expect to share or do for one another when they live in the same household, and otherwise is above and beyond typical activities family members provide for another adult family member without a disability.

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

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

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

Payments are only made for services that have been prior authorized and identified in the individual’s service plan. There are edits in the system that only allow for prior authorized services to be billed and paid. The planning team determines whether the paid family member providing the service best meets the individual’s needs. This support is documented in the ISP and regular service monitoring ensures the process is occurring.

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

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

○ **Other policy.**

Specify:

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

Interested providers contact the Division's Enrollment Team. The Division's Enrollment Team determines if the provider meets provider qualifications by reviewing documentation that serves as proof of requirements such as licensing, certification, accreditation, training, appropriate staff, etc. If the provider is qualified, the Division initiates a DMH Waiver contract with the provider and assists the provider with enrolling as a DD Medicaid Waiver provider through the Medicaid agency. All qualified, willing providers are assisted in enrolling as a waiver provider as provided in 42 CFR 431.51. The average time to enroll as a waiver provider is estimated to be 90-days.

Access to information regarding requirements and procedures for providers is available on the Division of DD website under "Information for Service Providers" and also available through the local regional office provider relations staff.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the 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:
The number and percent of licensed, accredited, or certified providers with authorizations to bill through the waiver. (Number of providers with authorizations to bill waiver services that are licensed, accredited, or certified divided by the number of providers with authorizations to bill waiver services)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of personnel records reviewed by Provider Relations during the time period identified meeting qualification requirements. (Number of personnel records reviewed by Provider Relations meeting qualification requirements divided by Number of personnel records reviewed by Provider Relations)

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sample will differ with provider services provided in accordance with Division Policy.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers surveyed by Licensure and Certification within established timelines. (Number of providers surveyed by Licensure and Certification within established timelines, within the time period identified divided by Number of providers due for Licensure and Certification survey within the identified time period.

Data Source (Select one):

Operating agency performance monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
Number and percent of non-licensed and non-certified self-directed employees meeting waiver provider qualifications. (Number of self- directed employees meeting waiver provider qualifications within the sample within the identified quarter divided by number of self-directed employees reviewed within the sample within the identified quarter.)

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

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

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Quarterly 1/12 sample individuals/designated representatives, of all employees working in the last 30 days at time of review. Records sampled are not reviewed again within the State's 3 year cycle.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
Number and percent of personnel records reviewed by Licensure and Certification during the time period identified meeting training requirements according to CSR. (Number of personnel records reviewed by Licensure and Certification during the time period meeting training requirements according to CSR divided by Number of personnel records reviewed by Licensure & Certification)

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: 100% of all new employees and 20% of employees for continuing training.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of personnel records reviewed by Provider Relations (PR) during the time period identified meeting training requirements according to the waiver service definition. (Number of personnel records reviewed by PR during the time period meeting training requirements according to the waiver service definition divided by Number of personnel records reviewed by PR)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of staff records providing personal assistance (PA) and/or respite reviewed by Provider Relations (PR) during the time period identified meeting training requirements (Number of staff records providing PA and/or respite reviewed by PR during the time period meeting training requirements divided by number of staff records providing PA or respite reviewed by PR during the time period)

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: 100% of providers in a 3 year cycle. Each provider has 3 employee records reviewed during the review for each authorized service.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

(a1, a5, c1): New applicants not meeting initial provider enrollment qualifications aren't enrolled as providers. Upon successful completion of the provider enrollment process, Provider Relations (PR) staff notifies DMH Licensure and Certification (L&C) Unit the provider is ready to pursue certification or license, if applicable for the services provided. The L&C Unit conducts a survey determining if standards for services are met and produces a written report within 30 calendar days of the site survey. If standards are met, L&C issues a provisional license or certificate for a period not exceeding 1 year. If the license or certificate is denied, the application process is terminated.

Once a provider obtains a certificate and contract, L&C reviews services every 2 years. L&C conducts a survey determining standards are met and produces a written report within 30 calendar days of the site survey; if standards are met, L&C issues a license or a certificate. If not, they must complete a plan of correction (POC) within 30 calendar days of receipt of the report. The L&C Unit then has 10 working days to accept or reject the POC. Necessity for additional site visit(s) is determined by the type, scope and extent of the issues for improvement. L&C, as well as PR contact at the Regional Office (RO), follow through on the process. Final determination of conformance to standards results in issuance or denial of the license or certificate. Issues identified through the L&C process are documented in the Information Quality Management Functions Database (IQFMD). The RO corrects authorizations made in error and files adjustments for claims paid in error and reports the action to the RO PR for resolution in the IQFMD. The provider may be required to disclose to the Missouri Medicaid Audit and Compliance Unit (MMAC).

(c-b2 and c-c2) PR staff determine conformance with qualifications for contract purposes. PR conducts a review on 3 year basis to assure non-licensed/certified/accredited providers are in compliance with contract requirements. In the event either an L&C or a PR Review finds unqualified staff, providers are required by contract to self-audit to the following provisions:

a. If the Department audit or review identifies unqualified staff were utilized in service delivery, the provider will conduct an internal audit of personnel files validating required staff training is complete and documented. The internal audit sample size shall be 100% or two hundred (200), whichever is less.

b. 1)If the internal audit report isn't submitted in the required 30 calendar days from the date of the identifying review/audit, the provider will implement an improvement plan.

2)If the provider's internal audit indicates they failed to maintain an 87% level of qualified staff, the provider implements an improvement plan.

d. In the event the provider fails to complete required internal audit and/or fails to submit required internal audit report within ninety (90) calendar days of the identifying review/audit, provider is advised that the Department will:

1)Place provider on the Critical Status/No Growth/No Referral list;

2)Notify L&C and/or the provider's accrediting entity; and

3)For informational purposes, notify MMAC.

Providers not maintaining qualifications are dis-enrolled as providers for waiver services. The RO corrects authorizations made in error and files adjustments for claims paid in error and notifies RO PR. The provider may be required to self-disclosure to Missouri Medicaid Integrity Unit. Individuals are offered other waiver provider options.

(b1) In addition to targeted training all self-directed employees must have background checks assured by the contractor and be registered with the FCSR before they can be paid for services. If it is found a worker didn't have a background check completed prior to beginning work, the VF/EA FMS contractor is notified within 10 days of discovery by the RO. The contractor must respond in writing within 30 days to the RO describing error correction. Case management staff assures the worker doesn't provide additional services until a check is completed satisfactorily. Administration staff will adjust authorizations and claims made or paid in error.

(c1): L&C conducts a survey determining standards are met and produces a written report within 30 calendar days of the site survey; if standards are met, L&C issues a provisional license or a certificate for a period not to exceed 1 year, if not, they must complete a POC within 30 calendar days of receipt of the written report. L&C then has 15 calendar days to accept or reject the POC. Necessity for additional site visit(s) is determined by the type, scope and extent of the issues for improvement. L&C, as well as the PR contact at the RO, follow through on the process. Final determination of conformance to standards results in issuance or denial of the license or certificate. If the license or certificate is denied, the contract is terminated. The RO corrects authorizations made in error and files adjustments for claims paid in error and reports the action to the RO quality assurance staff in writing, describing how the error was corrected and any remedial training provided to staff.

Providers accredited by CARF International or Council for Quality and Leadership (CQL) are deemed certified, as outlined in Missouri Code of State Regulation. Accredited providers submit a copy of their most recent accreditation survey and statement of accreditation to the Division of DD, verifying accreditation status is current

and noting areas of improvement identified, as well as an improvement plan, if necessary. The Division Standards and Accreditation Coordinator tracks to assuring reports are submitted and reviewed; if current status isn't on file, the Coordinator contacts PR at the RO to assist in obtaining required documentation.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

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

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

Stand-alone Respite Facility is a new provider for Out of Home Respite and Temporary Residential services. Stand-alone Respite facility providers must obtain Certification or Accreditation prior to enrollment with Medicaid and obtaining a contract with DMH. Stand-alone Respite facilities are assessed by Licensure and Certification and Provider Relations initially and ongoing for compliance with federal HCB Settings requirements prior to approval for enrollment. Using the state's established processes for site specific assessments ensures that every setting is fully compliant with the settings regulation prior to any service delivery. The state Medicaid agency ascertains through DMH enrollment approval and ongoing review that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing per 13 CSR 70.3.290 Home and Community Based Services Waiver Setting Requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Support Plan

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

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

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

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

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

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

Case Manager (Support Coordinator) qualifications are specified in the Medicaid state plan for Targeted Case Management for persons with DD approved by CMS effective July 1, 2018.This states that case managers employed by a qualified provider shall have one of the following qualifications: (1) A Registered Nurse; or (2) A Bachelor's degree from an accredited college or university. Case managers employed by a qualified provider on or before June 30, 2018 shall remain qualified.

☐ **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.

The individual will lead the person centered planning process where possible and the individual directs the process to the maximum extent possible. The individual's representative, family or guardian, and any other individuals they choose should have a participatory role. When individuals are children under the age of 18 living with their family, the parent(s) choose who they want to attend as a member of the planning team, and the parent(s) must participate in the meeting.

All support coordinators must be trained on the Division of DD Person Centered Planning Guidelines prior to facilitating an individual support plan. The guidelines describe person-centered planning as a process that is directed by the individual (waiver participant), with assistance as needed from a representative (support coordinator) and reinforces the responsibility of the support coordinator to ensure that waiver participants are full partners in the planning process.

A component of support coordinator's initial training is on the support planning process. The Individual Support Plan Guide is a component of the training which emphasizes the support coordinator role to encourage the participant/ family or guardian to actively engage in and direct the service plan development through the person-centered planning process, which includes:

- Individuals choosing people to participate in the process.
- Providing necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
- Is timely and occurs at times and locations of convenience to the individual.
- Reflecting cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
- Strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
- Offering informed choices to the individual regarding the services and supports they receive and from whom.
- Including a method for the individual to request updates to the plan as needed.

The guidelines are available to individuals and their families on the Division of DD's web page. The support plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated;

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The individual support plan is developed through a person-centered planning process. The person will lead the planning process where possible. The planning team includes the individual and his or her representatives, family or guardian, and other people chosen by the individual. If the individual is a minor or has been judged incompetent, the family or guardian must participate in the planning process and approve the plan. The team also includes providers selected by the individual. Other professionals involved with the individual may be included as applicable and at the individual's invitation. The individual leads the process and meetings are timely and occur at a time and location of convenience for the individual. The SC documents that the individual was present at the meeting and how the individual contributed. The plan is usually facilitated by a support coordinator employed by a Division of DD Regional Office or an approved TCM Entity. If the person so chooses, another facilitator may be used, but the support coordinator will participate in the planning.

No later than 30 days from the date of acceptance into the waiver program the interdisciplinary planning team develops a support plan with the individual. Initial plans must contain at least an accurate beginning profile of the person. The profile needs to reflect what the person sees as important in relationships, things to do, places to be, rituals and routines, a description of immediate needs, especially those that are important to the person's quality of life including health and safety and information about what supports and/or services are required to meet the person's needs. The plan facilitator must make sure that each item in the action plan has enough detail and/or examples so that someone new in the person's life understands what is meant and how to support the person. If the initial plan is not comprehensive, it can cover no more than 60 days, during which time a more comprehensive plan must be finalized.

The support plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. The plan must be distributed to the individual and other people involved in the plan.
(b) The plan is based on the support coordinator's functional assessment of the individual and all other assessments that are pertinent. The Division uses standard tools to determine level of functioning. Assessment specified in Chapter 2 of 9CSR-45 such as the MOCABI and Vineland are the typical tests of adaptive behavior for all waiver participants. Other formal normative based, standardized assessments of adaptive function may be used to supplement or replace the MOCABI and Vineland. In addition, educational, psychological and medical records, etc. may be used to assist in documenting the individual's diagnosis and level of functioning. Assessments include observations and information gathered from the members of the team.

The functional assessment determines how the individual wants to live, the individual's routines, what works for the individual and what does not. It also assesses what the individual wants to learn and how the individual learns best. It measures how independently the individual functions and what interferes with what the individual wants, and it suggests ways the individual's needs and wants can be met.

c) Upon being determined eligible for Division of DD services, each individual and/or legal representative, or guardian receives information regarding available services and programs, including information about the waiver. After needs are identified through the planning process, the support coordinator reviews this information once more and together with the individual and the interdisciplinary team specific services and supports are identified to meet the participant's needs.

d) ISPs must be written in accordance with Division of DD's ISP Guide and Missouri Quality Outcomes. The ISP Guide includes a description of mandatory plan components such as demographics; health and safety, who and what are important to the person; individual's strengths and preferences; what staff need to know and do to provide support; requirements of the family of a minor child or guardian, how the person communicates and issues to be resolved. Setting options are identified and documented in the plan, based on the individual's needs, preferences, and, for residential settings, resources available for room and board. The plan reflects the setting in which the individual resides was chosen by the individual.

The plan specifies all the services and supports that are needed and who is to provide them, to enable the individual to live the way the individual wants to live and learn what the individual wants to learn. Providing supports or making adaptations to the environment may be part of the plan. The plan specifies any limitations the planning team foresees in being able to support the individual in achieving these desires. Such limitations can be financial, temporal and/or can relate to health and safety.

(e) ISPs address all supports and services an individual is to receive. This includes services provided through the waiver, other state plan services and natural supports. For each need that is expressed, the plan must describe what support or

service is being provided to meet that need. Providers selected by the individual are responsible for providing services in accordance with the plan. The support coordinator is responsible for coordinating services provided by other agencies or individuals and monitoring the provision of services during routine monitoring visits.

(f) Each outcome on the plan must be accompanied by information regarding the person(s) responsible for assuring progress. Timelines for completion of each outcome is specified. Support Coordinators monitor this progress during plan review visits.

(g) ISPs are subject to continuous revision. At a minimum, the entire team performs a formal review at least annually. The support coordinator maintains at least quarterly contact with each individual, their family or guardian, with at least an annual face to face contact for the individual who resides in their natural home setting. Monthly face to face contact is required for individuals in residential placement. During quarterly contact, the support coordinator monitors the individual's health and welfare. Progress notes document the contact and whether the outcomes stated in the plan are occurring.

Support coordinators are responsible for reviewing the provider's notes at least quarterly, and for observing and documenting any problems, discrepancies, dramatic changes or other occurrences which indicate a need for renewed assessment. The support coordinator's review of the provider notes includes making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk. During this monitoring the support coordinator determines if the support plan continues to meet the needs of the individual and with the approval of and input from the individual, their family or guardian, and makes any necessary revisions.

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.

The ISP Guide requires that support plans identify risk to individuals to assure their health and welfare. When the individual will be learning or doing something that involves increased risk, the plan or action plan will describe: 1) Action taken to assure the individual is making an informed choice, including a description of what has been done to assure that the person clearly understands what risks are involved and possible consequences; 2) What the individual needs to know and the skills and supports that are necessary for the individual to achieve his/her goal; 3) How supports will be provided, skills that will be taught and by whom; 4) What others in the community need to know and do to provide support to the individual; and 5) What follow-up and monitoring will occur.

The Division is enhancing the process for health risk identification and planning for waiver participants.

This enhancement is the implementation and utilization of the Health Risk Screening Tool (HRST).

(HRST) is a tool used to provide early detection of health risks and destabilization. The MO HRST project has also designed standardized electronic Health Risk Support Plan (HRSP) templates in the HRS system which will support the team with identification of implementation strategies to mitigate risk and improve health outcomes. The completion of the HRST and any applicable HRSPs will align with the individual's annual Individualized Support Plan (ISP) meeting.

Information entered into the MO HRS system will be accessible electronically to all identified team members providing a more efficient and effective system for interdisciplinary team member communication and direct accessibility to identified health risk, planning and service information. This access will also provide a more efficient and effective process for ongoing monitoring to support ensuring individual waiver participant health and welfare.

The utilization of this process will be initiated in July of 2021 with full implementation of all waiver participants by March of 2024

Individualized back-up plans are based on the individuals assessed needs, and are documented in the ISP when needed. Providers and lead agencies are responsible for back-up plans and this is part of the service that they provide. There are back-up plans for everyone and the agency should inform individuals about what the back-up plan is and what is contained in the back-up plan. The support coordinator is responsible for ensuring that all back-up plans associated with the individual are incorporated into the individual's service plan.

Back up plans include a description of the risks faced when emergencies, such as lack of staff arises. The back-up plan also identifies what must be done to prevent risks to health and safety; how people should respond when an emergency occurs; and who should be contacted and when.

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.

When more than one provider of service is enrolled as a waiver provider, the individual or legal guardian is given a choice among eligible providers. The support coordinator educates and informs individuals regarding eligible providers of services to the individual or guardian during the annual planning process and at any time as needed. The Medicaid Waiver, Provider, and Services Choice Statement is used in conjunction with educating and informing individuals of eligible providers for documentation of provider choice. Documentation of education and choice of providers must be included in the annual plan.

Attached to the choice statement is the list of eligible providers for the given service. The Regional Office or TCM Entity that is providing support coordination is responsible for ensuring individual choice of provider statements are obtained and maintained in the individual's case record.

The Division of DD makes every effort to build provider capacity in rural areas. Each regional office has Provider Relations staff designated to work with provider development. If there are limited providers available for a chosen service the Division will work closely with the individual to identify other providers that would be willing to provide the needed service in the area of the state where the individual resides.

Accessible information on choice of qualified providers is provided by the support coordinator during the planning team meetings. The planning team utilizes the ISP guide which emphasizes the support coordinator role to provide accessible information on the choice of qualified providers, which includes:

- Providing necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
- Reflecting cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
- Offering informed choices to the individual regarding the services and supports they receive and from whom.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

DMH staff will complete a statistically valid number of record reviews on a quarterly basis to assure support plans are completed in accordance with waiver policies and procedures. Reports are produced quarterly and sent to MHD, which document the outcome of the reviews. MHD reviews the results of the DMH's review, including corrective actions, and determines if any additional action is needed. Supporting documentation will be available to MHD upon request.

In addition to the quarterly statistically valid sampling review performed by DMH, MHD also conducts their own review annually based upon a statistically valid number of participants. The review by staff from MHD ensures individuals receiving waiver services had a service plan in effect for the period of time services were provided. The review process also ensures that the need for services that were provided was documented in the support plan, and that all service needs in the support plan were properly authorized prior to service delivery.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

○ **Other schedule**

Specify the other schedule:

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

☐ **Medicaid agency**

☒ **Operating agency**

☐ **Case manager**

☒ **Other**

Specify:

Approved Targeted Case Management Entities that provide support coordination, including support plan development, maintain the support plans of participants for whom they coordinate services.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

a.) Monitoring the implementation of the support plan and the participant health and welfare is the responsibility of the planning team (Code of State Regulation 9 CSR 45-3.010). This process is facilitated by the support coordinator employed by a Division of DD Regional Office or an approved TCM Entity, and designated management staff from the community provider.

b.) & c.) Support plans and participant health and welfare are monitored and follow-up action is taken through the following processes and frequencies:

1) Support coordinators monitor health, fiscal issues, services and staff, environment and safety, and consumer rights during monitoring visits with the participant, per the Individual Support Plan Monitoring and Review Directive. Support Coordinators monitor all services and supports for the individual, which are developed through the person centered planning process and documented in the ISP. The Individual Support Plan Monitoring and Review process is driven by the supports and services which are identified in the ISP. This review is completed monthly for the services that require monthly monitoring and quarterly for those services that require quarterly monitoring. At a minimum of quarterly, the support coordinator monitors the health and welfare of the participant. This includes a review of the support plan to ensure service needs identified in the plan are being met. The review is accomplished by contact with the individual and/or responsible party, through observation, and review of documentation. If non-waiver service needs are identified in the support plan, the support coordinator determines the person or entity identified in the support plan as responsible for helping the individual access the service(s) and determines if services are being received as planned. Non-waiver services may include health services the individual accesses through State plan Medicaid services. Review of the support plan and the person's health and safety includes a review of the backup plan for participants.. Monitoring considers whether the backup plan has been implemented, and if so, whether the plan sufficiently met the individual's needs and whether all persons and entities named as part of the backup plan are still available to assist. If changes are needed to the backup plan, the service plan will be updated accordingly. Results are documented in a Monthly/Quarterly Summary. Back-up plans for participants served by agencies are required dependent upon an individual's assessed needs.

When an issue or concern is discovered around an individual's health, safety/environment, rights, money, services, or back-up plan, the Support Coordinator supervisor, individual's guardian and/or the provider's designated management staff are notified. If a concern is not an immediate risk to the person's health or welfare and cannot be quickly resolved then the support coordinator indicates the type of action plan that will be taken to address the issue. Concerns around the sufficiency of the backup plan shall be immediately resolved which will include a revised support plan. All issues/concerns identified from support monitoring and ISP Review processes and action taken and remediation are entered in the Division's Integrated Quality Management Functions Database (IQMFD) for trending and tracking purposes. Support coordinators are employed by the state or by TCM entities. Both are responsible for reporting information into(IQMFD) and for maintaining case notes.

If monitoring discovers there is a lack of progress on achieving the outcomes identified in the support plan, the Support Coordinator documents this and works with the individual and the interdisciplinary team to revise and amend the plan as needed. Support plan revisions can only be implemented with the approval of the individual or their guardian.

2) The Support Plan Review process ensures the individual planning process is person-centered and leads to quality outcomes for individuals. The process also evaluates the effectiveness of support services in meeting individual needs, identifies support service strengths, and areas needing improvement. Each person supported by the Division must have a support plan that meets the minimum criteria described in the Division of DD ISP Guide.
Support plans must be reviewed and updated if necessary on at least a quarterly basis. The review and update must also occur when:
a) the person or the person's guardian requests that information be changed or added;.
b) others invited by the person to participate in his/her support plan provide additional information;
c) needs for supports and services are not being adequately addressed;
d) a back-up plan failed or needs to be revised due to a change in the availability of persons named or entities named; or
e) the need for support and service changes.

3) The MHD reviews a randomly selected sample of waiver participant records annually. The compliance review includes looking at ISPs. Information reviewed may include the support plan, LOC evaluation, annual re-determination of the LOC, assessments used to determine the LOC, service reviews completed by support coordinators, provider monthly reviews of the support plan, provider choice statements completed by the individual, and waiver choice statements completed by the individual. The review by the MHD ensures all service needs identified in the support plan

are being met regardless of the funding source for support. If there is not evidence that a need in a person's support plan is being met, this is a review finding which will be referred back to the regional office or county entity. Depending on the urgency of ensuring the need is met, a phone call may be placed or the request for corrective action will be provided in writing. Division of DD staff is responsible for ensuring that corrective action is taken and for reporting the action to MHD.

4) A random review (statistically valid sample of 95% confidence level and a plus or minus 5% margin of error rate) of ISPs is completed on a quarterly basis. This includes both regional office as well as contracted TCM agencies which provide case management. The review is conducted by Division of DD staff on a statistically valid sample of waiver participants to ensure adherence to CMS waiver and Division of DD requirements.

(d) TCM TAC ISP Review monitoring includes ensuring the individual has free choice of provider for all waiver services. Initially a form is completed to reflect choice of provider. If a new service is initiated, or a new provider is identified, the support coordinator would complete a new form to verify provider choice. Quarterly a random sample of ISPs and associated documentation are reviewed through the ISP review process.

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 Support Plans in which services and supports are aligned with assessed needs. (Number of Support Plans indicating supports and services are aligned with assessed needs reviewed within the identified quarter divided by the total number of Support Plans reviewed in the identified quarter.)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of support plans addressing identified health risks. (Number of support plans addressing identified health risks as reviewed within the identified quarter divided by the total number of support plans reviewed in the identified quarter.)

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

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

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Representative sample .95 Confidence Interval that is stratified by region
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of support plans addressing participants' desired outcomes. (Number of support plans addressing participants' desired outcomes divided by the total number of support plans reviewed in the identified quarter.)

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of support plans reflecting safety risk factors and measures in place to minimize them, including individualized backup plans and strategies. (Number of plans addressing participants' safety risk factors divided by the Total number of support plans reviewed in the identified quarter)

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

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: Representative sample .95 Confidence Interval that is stratified by region
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 support plans are reviewed in accordance with the Division's ISP review policy for monitoring (Number of support plans reviewed in the identified timeframe with complete summaries as required for the previous 12 months divided by the Number of support plans required to be reviewed in the identified timeframe.)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of support plans in which the person participated in their plan development. (Number of support plans in which the person participated in their plan development in the identified timeframe divided by the Number of support plans reviewed in the identified timeframe)

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

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

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Representative sample .95 Confidence Interval that is stratified by region
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 plans in which the person/person's guardian signed and dated the plan prior to implementation. (Number of support plans where the person/person's guardian signed and dated prior to the implementation date divided by the number of plans reviewed within the identified quarter.)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of plans that describe what people need to know or do in order to support the person (Number of plans within the sample describing what people need to know or do in order to support the person divided by the Number of plans reviewed within the identified quarter.)

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

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

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Representative sample .95 Confidence Interval that is stratified by region
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 support plans updated/revised at least annually. (Number of support plans updated/revised at least annually divided by the Number of support plans reviewed within the identified quarter.)

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

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: Representative sample .95 Confidence Interval that is stratified by region
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of support plans that were updated to reflect current identified changes in need (Number of support plans reflecting current identified changes in need from quarterly reviews divided by the Number of support plans reviewed within the identified quarter.)

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants who receive services in the type, amount, frequency, and duration authorized in their support plan. (Number and percent of waiver participants who receive services as authorized in their support plan divided by the Number of waiver participants with authorized services within the identified timeframe.)

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of completed and signed Medicaid Waiver, Provider, and Services Choice statements specifying choice was offered between waiver services and institutional care. (Number of completed and signed Medicaid Waiver, Provider, and Services Choice statements confirming choice of waiver participation divided by the Number of records reviewed within the identified timeframe.)

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

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

		Representative sample .95 Confidence Interval that is stratified by region
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of completed and signed Medicaid Waiver, Provider, and Services Choice statements indicating choice was offered between providers (Number of completed and signed Medicaid Waiver Provider, and Service Choice statements indicating choice was offered between providers divided by number of records reviewed within the identified timeframe)

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

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

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Representative sample .95 Confidence Interval that is stratified by region
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
 # & % of records in compliance with completed and signed Medicaid Waiver, Provider, & Services Choice statements indicating choice was offered between waiver services. (# of records in compliance with completed and signed Medicaid Waiver, Provider, & Services Choice statements indicating choice was offered between waiver services divided by # of records reviewed within the identified timeframe)

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

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

	Ongoing	Specify: Representative sample .95 Confidence Interval that is stratified by region
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

D-a 1, 2, 3, and 4 and D-b 2, 3, and 4, D-c1 and 2 Designated Regional Office staff review a sampling of ISP support plans every quarter and communicate to support coordinators regarding any findings requiring remediation and track to ensure remediation occurs.
(a) If a plan does not meet criteria set forth in the ISP Guide, remediation may include training as needed. The director of a TCM entity is responsible for determining systems enhancements. If personnel actions are needed for individual support coordinators, including, but not limited to, training or re-training, verbal or written warnings, suspension or termination.
D-d 1 Assigned Support Coordinators as a component of their ongoing service monitoring enter findings requiring remediation into the division's IQMFD which is monitored by local QE to ensure remediation timelines are met.
D-b 1 Designated state level QE staff monitor on a quarterly basis established timelines to assure process is met. Any findings for remediation are followed up locally with applicable staff.
D-e 1, 2, and 3 Designated Regional Office staff review a sampling of Medicaid Waiver, Provider, and Services Choice Statements every quarter and communicate to support coordinators regarding any findings requiring remediation and track to ensure remediation occurs.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

a) Expectations for Person Centered Planning, reflect the values outlined in the Missouri Quality Outcomes. The outcomes acknowledge principles that people have control of their daily lives, and that plans should reflect how they want to live their life. Person-centered planning is the foundation in which people can determine the direction of their lives, identify the supports they will need, and how those supports should be delivered to assist them to move in their personally identified direction. The planning process is under the direction of the individual or a representative of their choice. The process identifies needs and how those will be met by both paid and unpaid supports, who will provide the supports, and how supports will be provided within agreed upon parameters.

b) Individuals/guardians or designated representatives may choose to self-direct personal assistant services, Individual Directed Goods and Services and community specialist services and be the employer though a Vendor Fiscal Employer Agent (VF/EA) Financial Management Services (FMS). All Individuals have a support coordinator trained to facilitate the person centered planning process. Individual/guardians or designated representatives direct how their individualized budget is to be expended to exercise control of their allocated resources. They have the option to have a support broker to provide information and assistance in order to help in recruiting, hiring, and supervising staff. The individual/guardian or designated representative is the common law employer with the assistance of a VF/EA FMS who will perform payroll, taxes, broker workers compensation, etc.

c) Resources available to support individuals who direct their services include the ability of the individual/guardian or designated representative to facilitate the support plan with the assistance of the support coordinator. The individual/guardian or designated representative recruits, hires and self-directs employees and performs other employer supervisory duties. Individuals/guardians or designated representatives may be authorized for a support broker to provide the assistance. VF/EA FMS' are required for individuals who self- direct. The financial management contractor provides the individual or representative with technical assistance in getting employees set-up for payroll services and in tracking expenditures. Support coordinators are responsible for monitoring: health and safety, ensuring individuals stay within budgeted allocations, and required documentation is created and maintained. Additionally the support coordinator is responsible in informing individuals of the option to self-direct. A support broker is an option for individuals who need additional information and assistance in managing and directing their employees. The self-directed supports coordinator is a state employee who is available to provide technical assistance, create system enhancements, track and trend issues, and provide oversight of the option to self-direct.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.

Select one:

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Only Personal Assistant, Individual Directed Goods and Services and Community Specialist may be self-directed. For individuals who do not choose to self-direct, waiver services are available through MO HealthNet enrolled waiver provider agencies. Only individuals who live in their own private residence or the home of a family member may self-direct.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or

entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) Individual/guardians or designated representatives learn about self-directed support options from the support coordinator during the person centered planning process when needs are identified and ways of supporting the needs are discussed. During the person centered planning process, individuals have the opportunity to weigh the pros and cons of participant direction. Self-directed supports is listed on the Medicaid Waiver, Provider, and Services Choice Statement. Individual/guardians or designated representatives also often learn about self-directed services from other individuals or families who are directing their own services. Information on self-directed support is included in the waiver manual which is available to the public. The waiver manual and the Individual handbook on self-directed support is also available on the DMH/Division of DD web-site. The information assists support coordinators in describing the benefits and processes for self-direction and provides written material for individuals and/or legal representatives on the specifics. Regional offices have a Self-Directed Coordinator that is available to provide technical assistance and guidance to support coordinator and other stakeholders. As part of the person centered planning process, the specialized needs of the individual are discussed with the planning team to identify any potential liabilities or risks the individual may face, and to determine a plan for how each potential liability and risk will be addressed.

b) DD TCM Entities providing support coordination are responsible for furnishing information on self-direct supports options.

c) DD TCM Entity support coordinators are trained on self-directed supports options. If the support coordinator hasn't been through the training, regional office self-directed coordinators may be asked to assist in providing information to the individual with the support coordinator. This information is presented during the person centered planning process when individual needs are identified and ways of supporting the needs are discussed, anytime the individual is dissatisfied with provider based services, or upon inquiry by the participant/guardian or designated representative.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

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

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

An Individual's Right to Have a Designated Representative

An individual who is eighteen (18) years or older, a guardian, or a parent (if the individual is a minor), may identify a designated representative for purposes of utilizing SDS. The designated representative is responsible for managing employee(s), acting in the best interest of the individual, in accordance with the guiding principles of self-determination. If a representative has been designated by a court, the legal guardian will identify themselves or another person as the representative.

A designated representative must:

1. Direct and control the employees' day to day activities and outcomes.
2. Ensure, as much as possible, that decisions made would be those of the individual in the absence of their disability;
3. Accommodate the individual, to the extent necessary, so that they can participate as fully as possible in all decisions that affect them; accommodations must include, but not be limited to, communication devices, interpreters, and physical assistance;
4. Give due consideration to all information including the recommendations of other interested and involved parties; and
5. Embody the guiding principles of Self-Determination
6. Not be paid to provide any supports to the individual.

The following people can be designated as a representative, as available and willing:

- A spouse (unless a formal legal action for divorce is pending)
- An adult child of the individual
- A parent
- An adult brother or sister
- Another adult relative of the individual
- Other representative if the individual wants a representative but is unable to identify one of the above, the individual along with their support coordinator, and planning team, may identify an appropriate representative. The other representative must be an adult who can demonstrate a history of knowledge of the individual's preferences, values, needs, etc. The individual and his or her planning team is responsible to ensure that the selected representative is able to perform all the employer-related responsibilities and complies with requirements associated with representing one individual in directing services and supports.

The planning team and VF/EA FMS must recognize the participant's representative as a decision-maker and provide the representative with all of the information, training, and support that would typically be provided to a participant who is self-directing. The representative must be informed of the rights and responsibilities of being a representative. Once fully informed the representative must sign an agreement which must be given to the representative and maintained in the participant's record. The agreement must list the roles and responsibilities of the representative, the roles and responsibilities of the VF/EA FMS , must include that the representative accepts the roles and responsibilities of this function; and state that the representative will abide by the VF/EA FMS policies and procedures. The designated representative must function in the best interest of the participant and may not also be paid to provide services to the participant. The individual can at any time revoke the agreement with the designated representative.

The non-legal representative signs an agreement which states they will act in the best interest of the individual and will comply with the program requirements. The choice of non-legal representative is reviewed by the planning team and documented in the ISP. Additionally, the support coordinator completes quarterly service monitoring as well as a quarterly provider reviews to ensure program rules are followed.

Service Monitoring takes place with each waiver participant as outlined in Appendix D-2. The monitoring process can lead to identifying issues with the representative not acting in the best interest of the waiver participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Community Specialist	☒	☒
Personal Assistant Services	☒	☒
Individual Directed Goods and Services	☐	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**

☒ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

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

Provide the following information

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

The Division of DD has a statewide contract with a VF/EA FMS provider for payroll services including, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance; pay invoices associated with individual directed goods and services. A single VF/EA FMS contractor is responsible for payroll functions. This contractor is also responsible for verifying the citizenship status and background screenings of new workers and making available expenditure reports to Individual. Reimbursement for FMS is an administrative service and not fee for service. The provider is not a governmental entity.

VF/EA FMS is responsible for maintaining a separate account for each participant's budget, tracking and reporting disbursements and balances of participant funds, and processing and paying invoices for goods and services approved in the service plan.

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

The Division pays the VF/EA FMS contractor for services provided with general revenue and seeks reimbursement through the MO HealthNet program as an administrative expense. VF/EA FMS are provided through a single statewide contract. The contractor is a private company. The contractor has a specific rate for each new worker added, each check written, etc. (by transaction). The contractor is paid for these services with general revenue and records of payments will be submitted for 50% reimbursement as administrative service in compliance with 45 CFR 74. VF/EA FMS are not reimbursed based on a percentage of the total dollar volume of transactions it processes. The VF/EA FMS sends a detailed invoice to the Division of DD monthly for the actual cost.

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

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

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

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

☒ **Other**

Specify:

The VF/EA FMS contractor is available for technical support to the participant/guardian or designated representative in completing paperwork to set up as an employer, completing paperwork for each new worker/employee, and facilitates background checks for all new workers. The VF/EA FMS maintains evidence of employee qualifications and service documentation on behalf of the individual and family. The VF/EA FMS contractor maintains an internet web-portal where worked time can be recorded. The participant/guardian or designated representative, the employees and staff at Regional Offices, and support coordinator have access to the secure web-based system to view payment information. Individual/guardians or designated representatives can view total amounts authorized, payments made to workers, and balances. Workers can view current payroll information as well as YTD. Regional office staff and support coordination staff can also view authorized amounts, payments, and balances.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of**

the participant-directed budget

☒ **Other**

Specify:

The VF/EA FMS maintains records of SDS employee qualification documents, maintains Service Documentation and provides Electronic Visit Verification (EVV).

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

Oversight of the VF/EA FMS entities:

a) Individual Directed Services are prior-authorized by the local Regional Office on a yearly basis based on the support plan. Dollars authorizations are sent to the VF/EA FMS by Central Office on a daily basis (M-F) based on the regional office authorizations. Employees input delivered services by entering time through the internet on the VF/EA FMS's web-portal or faxing paper timesheets. Regional Office staff has access to review information that is input. Individuals/designated representatives also have access to the system to approve services and to review their account of authorized and delivered services/dollars. The VF/EA FMS provider pays workers by direct deposit or a manual check, and calculates, files reports and pays taxes that are due. Employee pay stubs reflecting withholdings from gross payroll are available on-line or sent by regular mail, if requested, to the employee each pay period.

The VF/EA FMS maintains a web portal for the employer. The web portal generates live time reports per payroll expenditures, which itemizes reporting of wages for each employee, total payments, total dollars amounts paid on behalf of each participant. For individuals/designated representatives who do not have internet access reports are sent monthly by mail. These reports are made available to Regional Offices and support coordinators. Additionally the VF/EA FMS's processes and systems have quality controls that ensure accurate and appropriate billing. These include system "flags" that identify over-authorizations, duplicate services, duplicate individuals and correct codes/authorizations. This ensures that units billed will not exceed state Medicaid maximums, duplicate billing for same services, and employees only enter billing for authorized services.

b) Participant services are monitored by the TCM Entity support coordinator. If concern is noted, the QE leadership team is asked to conduct a further review.

DMH Central Office also monitors the VF/EA FMS to ensure contracted activities in support of self-directed services are completed in an individual centered, timely, and accurate manner. The VF/EA FMS also follows their own internal quality assurance plan to meet accounting controls and performance standards including communications, payroll processing, and reporting. Additionally, the VF/EA FMS arranges for an annual external CPA agency audit to insure financial internal controls are followed. This report is shared with Individual for whom the VF/EA FMS is providing contracted services.

c) Monitoring by the support coordinator is quarterly, unless there is reason to monitor more frequently. The VF/EA FMS contractor, as the agent for the participant/guardian or designated representative, receives all correspondence from federal, state and local employment-related tax and insurance entities and continuously monitors for problems. The VF/EA FMS shall make available all records, books and other documents related to the contract to DMH, its designee, and/or the Missouri State Auditor in an acceptable format, at all reasonable times during the contract period and for three years after the contract termination. The Missouri's State Auditor's Office routinely reviews all programs for problems when auditing each Division Regional Office and Central Office operations.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

☒ **Waiver Service Coverage.**

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental Accessibility Adaptations-Home/Vehicle Modification	☐
Transportation	☐
Individualized Skill Development	☐
Job Development	☐
Professional Assessment and Monitoring	☐
Physical Therapy	☐
Specialized Medical Equipment and Supplies (Adaptive Equipment)	☐
Community Specialist	☐
Support Broker	☒
Community Transition	☐
Dental	☐
Assistive Technology	☐
Community Networking	☐
Speech Therapy	☐
Supported Employment	☐
Benefits Planning	☐
Applied Behavior Analysis (ABA)	☐
Temporary Residential Service	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Assistant Services	☐
Family Peer Support	☐
Career Planning	☐
Individual Directed Goods and Services	☐
Day Habilitation	☐
Prevocational Services	☐
Occupational Therapy	☐

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

If an individual voluntarily requests to terminate individual direction in order to receive services through an agency, the support coordinator will work with the individual or legal representative to select a provider agency and transition services to the agency model by changing prior authorizations based on the individual's needs. The support coordinator and other staff with the Regional Office will make every effort for the transition to be smooth and to ensure the individual is not without services during the transition. If SDS is terminated, the same level of services will be offered to the individual through a traditional agency model.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

If the planning team determines the health and safety of the individual is at risk, the option of self-directing may be terminated. The option of self-directing may also be terminated if there are concerns regarding the participant/guardian or designated representative's willingness to ensure employee records are accurately kept, or if the participant/guardian or designated representative is unwilling to supervise employees to receive services according to the plan, or unwilling to use adequate supports or unwilling to stay within the budget allocation, or the participant/guardian or designated representative has been the subject of a Medicaid audit resulting in sanctions for false or fraudulent claims under 13 CSR 70-3.030.

Before terminating self-direction options, the support coordinator and other appropriate staff will first counsel the individual or legal representative to assist the participant or legal representative in understanding the issues, let the participant or legal representative know what corrective action is needed, and offer assistance in making changes. If the individual/guardian or designated representative refuses to cooperate, the option of self-directing may be terminated. However, the same level of services would be offered to the individual through an agency model.

During the involuntary termination process, the support coordinator and planning team helps the individual transition to an agency model of their choice. If it is an immediate health and safety issue, the support coordinator and planning team would arrange for immediate temporary supports until a long-term agency is chosen by the individual.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only			Budget Authority Only or Budget Authority in Combination with Employer Authority		
Waiver Year	**Number of Participants**			**Number of Participants**		
Year 1					401	
Year 2					440	
Year 3					483	
Year 4					530	
Year 5					581	

Appendix E: Participant Direction of Services

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

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

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

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer

(managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

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

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

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

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Division of DD Regional Offices pay the costs. The VF/EA FMS obtains the background checks.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

Specify:

The individual and/or designated representative approve self-directed employee electronic timesheets for services rendered by use of the VF/EA FMS web portal, or by providing signatures on paper timesheets.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

For an individual who is self-directing their services, the planning team determines needs based on gathered assessments . The participant and their planning team identify how they best meet the assessed needs. The team identifies how these needs can be met through informal supports and other sources. Any needs that cannot be met through these means will constitute the waiver individual budget.

The UR process reviews the budget along with the support plan to ensure the level of need reflected in the budget is documented in the support plan and that services and amounts of service requested are necessary and consistent with the level of services other individuals who have a similar level of need receive. Historical costs and prior utilization data are also used to project costs and develop the budget. When an annual plan and budget are being renewed, historical costs and prior utilization data become the basis for calculating the new budget.

The individual is notified in writing of the approved budget and plan. The notice includes appeal rights should an individual disagree with the outcome. This process, which is in state regulation, is explained to individuals by the support coordinator and is available to the public from the State's DMH web-site.

Any time an individual's needs change, the support plan can be amended and a new budget can be prepared. If the new budget results in increased level of funding, the support plan and budget will be reviewed through the UR process before final approval is granted. If an increase in service are needed immediately, an immediate increase can be approved out of the annual budget by the individual or their representative. The team must then meet to determine if an increase in the annual budget is necessary. The person centered planning process including the budgeting process is explained to individual by the support coordinator. Information on the person centered planning process and the UR process which is in state regulation, are available to the public from the State's DMH web-site.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The method used to determine the individual budget is as follows. Needs of the individual are identified in the Support Plan. The individual along with the planning team determines how the needs can be best met through natural supports, or paid supports and a budget is drafted to meet the individual's needs.

The budget and support plan is reviewed by the UR Committee. UR considers the budget request in comparison with the level of funding that is approved for other individual with similar needs and either recommends the Regional Office Director approve the budget or approve the budget with changes.

The individual is notified in writing of the approved budget and support plan. The support plan has to be signed by the individual or guardian to be implemented. The notice includes appeal rights should an individual disagree with the support plan and budget.

The written notice includes information on the individual's right to a fair hearing and offers help with the appeal process. They may first appeal to the Regional Director. If they are dissatisfied, they have appeal rights through both the DMH and DSS. While individuals are encouraged to begin with the DMH's hearing system, they may skip this hearing process and go directly to the DSS, MO HealthNet Division (Single State Medicaid Agency) hearing system.

Individual/guardians or designated representatives may request changes to budgets as needs change. For example, they may authorize more services be provided in one month and less in another month. Or, if needs increase, they may request additional services. When additional services are requested, the budget must be approved through the UR process. If an increase in services are needed immediately, an immediate increase can be approved out of the annual budget by the individual or their representative. The team must then meet to determine if an increase in the annual budget is necessary.

All Regional Offices administer the UR process according to state regulation.
Individual/guardians or designated representatives served by the Division of DD and providers are provided information on the UR process.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be

associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Services are prior authorized on a yearly basis based on the needs and history of the individual. Individuals/guardians and designated representatives are informed of the amount of service that may be provided within that authorized period.

During the course of service implementation the individual, or if applicable, the designated representative provides a monthly services summary to the support coordinator.

The support coordinator during service monitoring, on at least a quarterly basis and more frequently as needed, is responsible to ensure that services are being delivered as they are authorized. If services are being underutilized, the support coordinator will seek to determine the reason for under utilization and will ensure the individual's health and safety are not at risk. The support coordinator is responsible for ensuring the individual has the necessary support to recruit, schedule and supervise employees and will assist the individual in accessing help as needed. A support broker assessment used to determine what supports are needed.

If an individual is at risk of exceeding the budget authorizations, the support coordinator will counsel the individual and document within the monitoring system. The Regional Office self-directed support coordinator will help create an improvement plan if needed. Also as part of the services approval process, the VF/EA FMS has a system that tracks real time service utilization for each individual. This is to ensure that only services authorized are billed.

The VF/EA FMS has safeguards and notification built in their system with alerts to the support coordinator and self-directed coordinator if an individual goes over authorizations. The VF/EA FMS posts real-time self-directed services allocations and usage on a secure, password protected website for the benefit of individuals who are self-directing so they can keep track of budget utilization to date and amounts remaining in their allocation. This can be viewed by the individual, designated representative, support coordinator and regional office designees. For individuals who self-direct services and utilize paper timesheets for their staff, the VF/EA FMS send out a monthly spending summary. If it is determined that the individual is at risk of exhausting budget allocation a support broker can be added to provide information and assistance to help the individual better manage the day to day activities of self-directing. If the issue cannot be resolved, the team may need to discuss termination of self-directed supports and transitioning to traditional agency provider supports.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Medicaid rights of due process are extended to persons who participate in the DD PFH Waiver. Support Coordinators provide the division's rights brochure to individuals upon entry to the waiver and at least annually during the person centered planning process. In addition, information is posted on the division's web-site. Individuals have free choice of contracted provider and have the choice of HCBS or institutional services.

When adverse action is necessary such as termination, reduction of services, suspension of services, etc. the Division of DD Regional Office is responsible for notifying the participant in writing at least ten (10) days prior to any action being taken. The service coordinator is copied on the notice. Individuals have the right to appeal anytime adverse decisions are made or actions are taken. Support coordinators provide assistance to individuals in pursuing a fair hearing if requested by the individual. Upon notification of the intent to appeal an adverse action, services are automatically continued until resolution of the appeal. Notification of appeal can be made either verbally or in writing to the DMH and/or DSS, MHD.

While not required to do so, individuals are encouraged to begin with the DMH's appeal process. The individual may, however, appeal to the MHD, before, during and after exhausting the DMH process. However, once the individual begins the appeal process with the DSS, all appeal rights with the DMH end since any decision by the single State Medicaid Agency would supersede a decision by DMH.

If the result of the agency's decision is upheld, the individual may be required to pay for the continued services. If the agency's decision is overturned, the participant is not responsible for the cost of services. Copies of written notices of adverse action and requests for a Fair Hearing are kept in the individual's record maintained by the regional office or TCM entity.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

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

(a) The DMH has an appeal process that can be utilized by individuals. Appeals are directed to the DMH Hearings Administrator in the Office of DMH General Counsel.

The Division of DD also has a UR Process defined in the Missouri Code of State Regulation (9 CSR 45-2.017) that applies to all Regional Offices. The Utilization Process is used to ensure that access to services are fair and consistent statewide, plans reflect individual's needs, levels of services are defined and documented within the outcomes of the plans, and plans meet all requirements. If, through the UR Process the decision of the Regional Office Director results in the denial, reduction, or termination of a specific service then the individual must be informed in writing at least 10 days in advance of the adverse action, must be given the reason for the action, and must be given information regarding his/her rights to appeal the decision of the Regional Office Director.

(b) If an individual is notified by a Regional Office that he/she is ineligible for services or ineligible for continued services he/she may appeal the decision. (See below appeal process) If an individual is eligible for some services but not for a specific service the appeal steps are the same (as below) except that the individual must first appeal to the case management supervisor before appealing to the regional office director. The individual must appeal to the case management supervisor in writing or orally within 30 calendar days after being notified that they are ineligible for the specific service.

Appeal Process: The individual must appeal to the Regional Office Director within 30 calendar days after receipt of written notice of their ineligibility. The individual will receive the Regional Office Director's decision on the appeal within 10 working days after the request for appeal is received. If the individual does not agree with the Regional Office Director's decision the individual can, within 30 days after receiving that decision, notify the Regional Office intake or support coordination staff and request that an appeals referee hear the case. The individual will receive written notice that the Regional Office received their request for an appeal hearing. The appeals referee then notifies the individual in writing with the date, time, and location of the hearing. The notice is given to the individual at least 30 calendar days before the hearing and no more than 60 calendar days after the individual first requested the hearing.

An individual may receive documents that relate to his/her appeal without charge. The documents shall be furnished to the individual within five (5) working days after the individual requests the documents. The appeals referee bases his or her decision only on information presented at the hearing. The Regional Office Director must convince the referee that the Regional Office's denial of services was correct.

During the hearing the individual, the individual's representative, or the Regional Office Director may speak, present witnesses, submit additional information relating to the appeal, and question witnesses. The referee records the hearing and the tape is kept for one (1) year after the hearing and is available for review by the individual or their representative. Within 30 calendar days after the hearing the individual receives written notice of the referee's decision.

If the individual disagrees with the referee's decision he or she may request that the decision be reversed or changed or appealed to the Director of the DMH. Within 30 days of the decision, the referee may reverse or change the initial appeal decision at the request of the individual, the individual's representative, or the Regional Office Director.

If the individual appeals to the department director, the individual, the individual's representative, or the Regional Office Director may present new evidence or comment on and object to the hearing decision within ten (10) working days of the individual's notice of appeal. The department director considers evidence contained on the tape recording of the appeals hearing and considers other evidence presented. Within 20 working days after receiving notice of an individual's intent to appeal the department notifies the individual and the Regional Office Director of the department director's decision. That notice is the final decision of the DMH.

If the individual disagrees with the decision of the director of the DMH he or she may appeal to the Circuit Court, according to Chapter 536 of the Revised Statutes of Missouri (RSMo).

(c.)Individuals can at any point in the DMH appeal process appeal to the DSS, MHD. However, once an appeal is filed with the DSS, all appeal rights with DMH cease since DSS is the single State Medicaid Agency and any decision through that agency would supersede a decision made by the DMH. Participants and/or responsible parties are informed this dispute resolution mechanism is not a pre-requisite or substitute for a fair hearing.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

Missouri Department of Mental Health

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

The Office of Constituent Services (OCS) was created in 1997 to serve as an advocate for individuals who receive services from the DMH and their families. The office provides support to individuals and family members who have DD, substance abuse problems, and mental illnesses. The main goals of the office are to ensure individual's rights are not being violated; to review reports of abuse or neglect; and to provide useful information to individuals and family members about mental health issues.

(a) Individuals and family members may contact the office about suspected abuse, neglect, violation of rights, or concerns regarding mental health facilities or community providers by calling the toll-free number, completing and mailing a complaint form, sending an email to OCS, or writing to the DMH, OCS. Individuals are informed that the DMH complaint resolution mechanism is not a prerequisite or substitute for a fair hearing through the Medicaid Agency.

(b) & (c) When a complaint is received in the OCS the staff notifies the Division of DD's QE Leadership team as soon as the complaint is processed. All complaints received by the OCS are emailed/copied to the Division of DD QE Leadership team. The OCS includes the Event Report number on all correspondence for tracking purposes and includes the Event Report number in the subject box of the email.

Before the Division of DD is notified of a complaint the OCS checks the Division of DD Information System to verify the consumer or service is associated with the Division of DD before forwarding the complaint to the Division of DD.

(1) OCS e-mails information regarding the complaint within 1 working day to the designated DD facility.

(2) The DD Facility Director or designee determines if: (i) An Abuse/Neglect investigation is warranted, or (ii) An inquiry is warranted. (An inquiry is initiated when there is a complaint or suspicion of abuse, neglect, misuse of funds or property. (iii) All follow-up information regarding the complaint is forwarded within 10 working days to the local QE member with information that includes who was contacted, any follow-up that was, or is being done. This information is sent to the local QE member, who reviews the information for completeness. If the local QE member has questions, the response is returned to the DD Facility for clarification. Once the issues are adequately addressed, the complaint is forwarded to the Division of DD Consumer Safety Coordinator, who then reviews follow-up and resolves in the Event Management Tracking (EMT) System. (iv) If the person is not a DMH consumer or DMH does not have investigative authority and Abuse or Neglect is suspected, the DD Facility informs the OCS who then notifies the Family Support Division (FSD) if the individual is younger than 18 or DHSS if the individual is 18 or older. The complaint is considered resolved upon referral to the appropriate investigative authority. (v) A complaint is not considered valid, if there is no apparent violation of a DMH standard, contract provision, rule or statute, or there is no valid concern that a practice or service is below customary business or medical practice. If the complaint is not valid it is considered closed upon receipt of the response.

(3) A complaint is resolved when: a) all follow-up action is entered into the EMT system; b) the issues in the complaint are addressed by the facility; c) the reason the complaint is not a valid concern is documented.

The Division’s complaint resolution procedure is that within 10 business days, personnel designated by each DD facility will complete follow up to each complaint requiring a response to resolve with DMH OCS.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

System:
The state has a system for reporting and investigation of critical events or incidents. The system for identifying, reporting, and investigating critical events and incidents is outlined in the Code of State Regulations, the DMH Operating Regulations and Division of DD Directives.

Entities Required to Report:
Division Directive 4.070 & State Operated Program Waiver Policy requires DMH-DD Staff, contracted TCM entities & Contracted Provider Staff are to report the following events:

1. All events where there is a report, allegation or suspicion that an individual has been subjected to Misuse of Consumer Funds/Property, Neglect, Physical Abuse, Sexual Abuse or Verbal Abuse. (9 CSR 10-5.200, DOR 2.205, DOR 2.210)

2. All
a. Emergency room visits,
b. Non-scheduled hospitalizations,
c. Deaths of individuals served by DD,
d. Med Errors which reach an individual,
e. Incidents of Falls, The apparent (witnessed, not witnessed or reported) unintentional sudden loss from a normative position for the engaged activity to the ground, floor or object which has not been forcibly instigated by another person.
f. Uses of Emergency Procedures with an individual.
Emergency Procedures- any restraint/time out used by DMH staff or contracted staff to restrict an individuals' freedom of movement, physical activity, or normal access while in DMH services. If any of the following restraint types or time out occurs as defined they must be reported on an EMT form.
- Chemical Restraint- a medication used to control behavior or to restrict the individual's freedom of movement and is not a standard treatment for the individual's medical or psychiatric condition. A chemical restraint would put an individual to sleep or render them unable to function as a result of the medication. (A pre-med for a dental or medical procedure would not be reported as a chemical restraint.)
- Manual Restraint- any physical hold involving a restriction of an individual's voluntary movement. Physically assisting someone who is unsteady, blocking to prevent injury, etc. is not considered a manual restraint.
- Mechanical Restraints- any device, instrument or physical object used to confine or otherwise limit an individual's freedom of movement that he/she cannot easily remove. (The definition does not include the following: Medical protective equipment, Physical equipment or orthopedic appliances, surgical dressings or bandages, or supportive body bands or other restraints necessary for medical treatment, routine physical examinations, or medical tests; Devices used to support functional body position or proper balance, or to prevent a person from falling out of bed, falling out of a wheelchair; or Equipment used for safety during transportation, such as seatbelts or wheelchair tie-downs; Mechanical supports, supportive devices used in normative situations to achieve proper body position and balance; these are not restraints.)
- Time Out- The involuntary confinement of a consumer alone in a room or an area from which the consumer is physically prevented from having contact with others or leaving .

3. All events where there is Law Enforcement involvement when the consumer is either the victim, alleged perpetrator, or law enforcement is called in support in the event.

4. All events of fire, theft, or natural disaster resulting in disruption of DMH-DD service to consumer/s.

5. All events where there is sexual conduct involving an individual and it is alleged, suspected or reported that one of the parties is not a consenting participant.

6. All events involving a consumer when there is a realistic threat or physical action of serious self-harm or assault of others.

7. All events where the consumer ingests a non-food item. Non-food item-an item that is not food, water, medication or other commonly ingestible items.

8. All events that result in a need for an individual to receive lifesaving intervention or medical/psychiatric emergency intervention.

In addition to the above list State Operated Programs (SOP)/Regional Office staff is required to report the following:

9. All events that involve Employee Misconduct as outlined in DOR 2.220

10. All events that involve a DMH staff with serious injuries as defined by DOR 4.270. Serious injury an injury that results in the hospital admission of the injured person.

The state defines abuse and neglect as: (9 CSR 10-5.200, DOR 2.205, DOR 2.210):

Neglect- Failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any consumer when that failure presents either imminent danger to the health, safety or welfare of a consumer, or a substantial probability that death or physical injury would result.

Misuse of funds/property- The misappropriation or conversion for any purpose of a consumer's funds or property by an employee or employees with or without the consent of the consumer or the purchase of property or services from a consumer in which the purchase price substantially varies from the market value.

Physical abuse- An employee purposefully beating, striking, wounding or injuring any consumer; in any manner whatsoever, an employee mistreating or maltreating a consumer in a brutal or inhumane manner; or an employee handling a consumer with any more force than is reasonable for a consumer's proper control, treatment or management.

Verbal abuse- an employee making a threat of physical violence to a consumer, when such threats are made directly to a consumer or about a consumer in the presence of a consumer.

Sexual abuse: Any touching, directly or through clothing, of a consumer by an employee for sexual purpose or in a sexual manner. This includes, but is not limited to: 1. Kissing; 2. Touching of the genitals, buttocks, or breasts; 3. Causing a consumer to touch the employee for sexual purposes; 4. Promoting or observing for sexual purpose any activity or performance involving consumers including any play, motion picture, photography, dance, or other visual or written representation; 5. Failing to intervene or attempting to stop inappropriate sexual activity or performance between consumers; and/or 6. Encouraging inappropriate sexual
activity or performance between consumers.

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The State defines critical incidents as (DOR 4.270):

Critical events that are required to be reported are;
(A) Death of a consumer suspected to be other than natural causes;
(B) Serious injury to a consumer;
(C) Death or serious injury to a visitor at department state operated facilities;
(D) Death or serious injury to a department employee or volunteer while on duty;
(E) Incidents of abuse/neglect, including abuse/neglect involving death, serious injury and sexual abuse;
(F) Suicide attempt resulting in an injury requiring medical intervention (greater than minor first aid);
(G) Elopement with law enforcement contacted or involved;
(H) Criminal activity reported to law enforcement involving consumer as perpetrator or victim when the activity occurs at a facility. If not at a facility, then the criminal activity is serious (felony, etc.);
(I) Fire, theft, or natural disaster resulting in extensive property damage, loss or disruption of service and;
(J) Any significant incident the facility head, district administrator, provider administration or designee decides needs to be reported.

Method of Reporting & Timelines for Reporting:
• Required reporters immediately notify the Department with a written or verbal report of all required events of death, abuse, neglect or misuse of consumer funds/property or critical events. If a verbal report either by phone or in person is given, the contracted provider must send a completed event report form to the Department or directly enter the event into the EMT system by the end of the next business day from the date the event occurred or was discovered.
• All other events (not death, A/N or critical) meeting the reporting criteria must be reported by submission of an event report form or direct entry into EMT by the end of the next business day from the date the event occurred or was

discovered.
• The Code of State Regulations (9 CSR 10-5.200) requires that any director, supervisor or employee of any residential facility, day program or specialized service, that is licensed, certified or funded by the DMH immediately file a written complaint if that person has reasonable cause to believe that a consumer has been subjected to abuse or neglect while under the care of a residential facility, day program or specialized service.
• For all Department employees, complaints of abuse, neglect, or misuse funds/property shall be reported and investigated as set out in Department Operating Regulation 2.205 and 2.210. These reports shall be entered into the EMT System database within 24 hours or by the end of the next working day after the incident occurred, was discovered, or the notification was received.

Processing of reports:
All reports of events are processed through the Regional Office/State Operated Waiver Provider. The Regional Office/ State Operated Waiver Provider assures proper notification of Law Enforcement (when required), DHSS (when required) and Children's Division (when required). If a report of suspected abuse and neglect is received, the Regional Office/ State Operated Waiver Provider designated employee is also responsible for notifying the complainant and parent/guardian.

- The Regional Office/ State Operated Waiver Provider requests an investigation through the DMH centralized Investigations Unit for all allegations meeting reasonable cause threshold of: Physical Abuse, Verbal Abuse, Neglect, Misuse of Consumer Funds/Property, and Sexual Abuse.

- In the case of a death the DMH notifies the Executive Director of Missouri Protection & Advocacy Services via e-mail of all consumer deaths that involve any or all of the following:
  a. Death resulting from a consumer being restrained and/or secluded;
  b. Death resulting from suicide;
  c. Death deemed suspicious for abuse or neglect;
  d. Any unexpected death; or
  e. Death with unusual circumstances.

Information provided to Missouri Protection & Advocacy Services via e-mail to the Executive Director includes:
  a. Consumer's name;
  b. Consumer's guardian, if one is appointed;
  c. Contact information for guardian;
  d. Consumer's Social Security Number;
  e. Consumer's date of birth;
  f. Consumer's date of death
Regional Office/ State Operated Waiver Provider Directors, or designated staff, are required to report such deaths to their Division Directors (for community deaths) or the Director of Facility Operations (state operated) within 24 hours of notification of death.

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

Training and information:

- Support Coordinators annually provide training and education by reviewing a reference guide with to help individuals and families understand their rights. The reference guide specifies rights consumers receiving services through the Division of DD have under Missouri state law (Sec. 630.15, RSMo.) The brochure also informs consumers and their parents or guardians, they can contact the DMH OCS if they think they are being abused, neglected, or have had rights violated. Contact information includes e-mail address, a toll-free phone number and a toll phone number, fax number, and mailing address. Support Coordinators also obtain annually a signed Client's Rights Receipt to demonstrate rights information was provided to the consumer or legal guardian.
- The Missouri DMH has a web site https://dmh.mo.gov/ which provides consumers and families a link to the OCS where information about consumer rights, detecting and reporting abuse & neglect, the abuse/neglect definitions, and the Reporting and Investigation process which includes contact information. The DMH Client Rights brochure and other information regarding consumer rights and abuse/neglect is posted on this web site at https://dmh.mo.gov/constituent-services. The site also has a consumer safety video at this site which discusses abuse and neglect and the reporting and investigation process, as well as the brochure Keeping Mental Health Services Safe which is a written version of the video.
- The brochure on Individual Rights of Persons Receiving Services from DD is located at https://dmh.mo.gov/media/pdf/individual-rights-persons-receiving-services-division-developmental-disabilities.

Who is responsible:

- Assigned Division of DD or TCM entity Support Coordinators as discussed above.
- The Division of DD Consolidated Contract requires that each provider gives participants the name, address, and phone number to the DMH OCS. Each consumer is informed that they have the right to contact this office with any complaints of abuse, neglect, or violation of rights.

Frequency of training:

- Annually with each consumer.

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

Entities Receiving Reports:
Each Regional Office/ State Operated Waiver Provider facility receives all written event report forms.

Report evaluation:
Reports are individually evaluated against set criteria for referral to the appropriate entity. Designated DD staff make decisions of follow up based on information provided at the time of the event notification and then review all written event reports within one business day of entry into the EMT system to determine if additional action is required by the division.

The criteria for referral is as follows:

All of abuse and neglect, and misuse of funds which meet the criteria for reasonable causes are submitted to the DMH Central Investigations Unit for investigation.

If the provider reporting a critical event is responsible for oversight/safety of the consumer, action must be taken to assure the welfare of the consumer. The Regional Office/ State Operated Waiver Provider facility may intervene by placing monitoring processes and staff at the program site, moving individuals from a home and/or terminating contract when appropriate.

If there is an allegation of abuse or neglect and the alleged victim is a resident or client of a facility licensed by the DHSS or receiving services from an entity under contract with DHSS then phone referral is made DHSS,

- o If there is an allegation of abuse or neglect and the alleged victim is under 18 years of age a phone referral is made to Missouri DSS/Children's Division
- o If there is alleged or suspected sexual abuse; or abuse and neglect that results in physical injury, or abuse/neglect or misuse of funds/property which may result in criminal charge this is reported to local law enforcement.
- o Missouri Protection and Advocacy is notified by e-mail of all consumer deaths that involve any or all of the following;

- Death resulting from a consumer being restrained and /or secluded
- Death resulting from suicide
- Death deemed suspicious for abuse or neglect
- Any unexpected death; or
- Death with unusual circumstance.

Entity responsible for conducting investigations & timeframes:
Upon receipt of a report from the head of the Regional Office/ State Operated Waiver Provider facility Director, or designee, the Central Investigations Unit assigns an investigator immediately. The assigned investigator initiates contact with the provider to arrange for securing evidence and such other activities as may be necessary.

A final report of the findings is sent to the Regional Office/ State Operated Waiver Provider facility within 30 working days. Upon receipt of the final report the Regional Office/ State Operated Waiver Provider Director has 20 calendar days to make a preliminary determination. If the preliminary determination substantiates abuse or neglect the alleged perpetrator is notified by certified mail. The contracted provider is also notified in writing and required to take appropriate action pertaining to the staff receiving the substantiation. The Regional Office/ State Operated Waiver Provider may request, if not already addressed, additional action to minimize the reoccurrence of a similar event. Further details including the appeals process are described in 9 CSR 10-5.200, Department Operating Regulation 2.210 and 2.205.

Informing Consumer/Guardian:
The Regional Office/ State Operated Waiver Provider notifies the consumer/guardian and follows up by mail within 10 working days from receipt of an allegation if an investigation has been initiated. Immediately after an investigation is completed and after the effective date of any disciplinary action, the Regional Office/ State Operated Waiver Provider provides written notification to the consumer/guardian of the findings of the investigation, a summary of the facts and circumstances and actions taken, except that the names of any employees or other consumers shall not be revealed.

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

Entity for overseeing incident management system:
The Missouri DMH, Division of DD is responsible for the oversight of the state's event management system which currently includes one database: EMT system. All critical incidents as defined in G 1-a, event responses, investigation findings and timelines, are input and monitored through the EMT system.

Process of communication:
Regional Office/ State Operated Waiver Provider and Support Coordinators are notified of events, including actions taken to protect the health, safety, and rights of the participants and to prevent reoccurrence.

Data collection:
o Designated DD QE Staff analyze aggregate reports of incidents from the EMT database at least quarterly, identifying trends and patterns. These identified trends are incorporated into provider Quality Management Plans, plans of action, and/or the participant's plan of care as indicated.
o Event data is reported in related performance measures to the Medicaid Agency quarterly.
o When there are consistent repetitive concerns or lack of progress on plans, the stakeholders of the provider are notified including the MHD (state Medicaid agency), DMH L&C, or the accrediting body (CARF or The Council on Quality and Leadership.)
o The Division of DD QE Leadership Team prepares a statewide report which includes quality assurance and improvement recommendations to prevent reoccurrence of patterns, trends and systemic issues. Findings and recommendations are submitted to the Division Director of DD.

Appendix G: Participant Safeguards

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

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

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

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

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

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

Mechanical restraints are not allowed in community settings. Physical restraint and chemical restraint may be permitted. Physical restraint is any manual hold of one person by another which restricts voluntary movement. Physical restraint does not include physically guiding a person during activities such as skill training.

Chemical restraint is defined in section 630.005, RSMO, and these medications are only administered with the primary intent of restraining a patient who presents a likelihood of serious physical injury to himself or others, not prescribed to treat a person's medical condition. The administration of medication for chemical restraint must be ordered by a physician and the order must include specific instructions for when it may be used. All administration of medication for chemical restraint must be documented in the participant's record. Chemical restraint is administered only in an emergency situation where all other less restrictive interventions are tried first and found ineffective; there are clear indications of imminent harm to the individual or others; and is included in the person's safety crisis plan. If it is used, the consumer cannot be left alone after administration and the affects must be monitored and documented, including intended and unintended effects, side effects, breathing, consciousness, and allergic or other adverse reactions.

Physical restraint techniques are limited to those that have been approved by the Division and determined unlikely to cause undue physical discomfort, pain or injury to an individual and included in the individual's safety crisis plan. Requests for use of crisis management systems other than Mandt or Non-Violent Crisis Intervention/Crisis Prevention (NCI/CPI) must be made to the Chief Behavior Analyst of the division in writing.

In addition to those general concepts, staff is also required to have knowledge of the individual's personal plan which may include additional specific techniques to employ with the individual to avoid situations escalating to physical restraint use. During the use of physical restraint, staff must monitor for intended and unintended effects, including any adverse reactions, the individual's breathing, consciousness, position of limbs.

Physical restraint is used only in an emergency situation where all other less restrictive interventions are tried first and found ineffective; there are clear indications of imminent harm to the individual or others; and is included in the person's safety crisis plan.

There are prohibited restraint techniques that include physical restraint that interferes with breathing; any technique in which a pillow, blanket or other item is used to cover the face; prone restraint; restraints which involve staff lying or sitting on top of a person; and those that use hyperextension of joints.

The Division of DD supports the use of Positive Behavior Supports concepts. Staff is required to have an introduction to the concepts upon hire and, again, knowledge of the individual's personal plan which, if indicated for the individual, would include the positive supports to be implemented. Positive Behavior Supports are also designed to mitigate the use of restraint. The service contract for providers specifies that training of MANDT, CPI, or other approved system prior to utilization of the techniques is required. The training required for MANDT, CPI, and other systems is competency based.

The Division of DD has policies governing the use of restraint, and requires documentation of all uses of restraint. In addition, each contracted provider is required to have a policy for its organization around restraint. During Certification surveys, these policies are reviewed for content and compliance with state requirements. In addition, providers who are accredited by a nationally-recognized body must meet the standards outlined by that accrediting body, including any related to the use of restraint. Accredited providers are required to submit their current accreditation report and thus the Division is informed of conformance to those standards.

The division utilizes an EMT system to track reportable events in accordance with state regulation 9 CSR 10-5.206 & Division Directive 4.070. An EMT Event Report form is completed by the person(s) involved in the physical and/or chemical restraint and these are sent to the Regional Office/ State Operated Waiver Provider for entry into the EMT system. Reporting is governed by Missouri administrative rules, known as Code of State Regulations (CSR). The Regional Office/ State Operated Waiver Provider reviews the event report where they may identify an unauthorized use of restraints. The support coordinator could also discover an

unauthorized restraint was used through review of the event summary or Service Monitoring (i.e. in conversation with the individual/staff, review of progress notes, etc.) A support coordinator could determine that the restraint is unauthorized if it is not implemented as outlined in the individual's safety/crisis plan or it is a restraint that is not approved by the Division.

Data is aggregated by region, by provider and by individual, analyzed and reported quarterly to further identify patterns and trends of use, both for consumer and for provider. Data is reported in related performance measures to the Medicaid Agency quarterly.

When a restraint is reported to the Regional Office/ State Operated Waiver Provider a designated staff reviews that event to determine if the restraint was a prohibited procedure or if more force than necessary was used in the restraint procedure. If the restraint is determined to be necessary to support the individual, it must be reviewed by the Regional Office/ State Operated Waiver Provider Due Process Committee.

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

The State agency is responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed.

Division Directive states the event report must be entered into the EMT system by the end of the next business day from the date the event occurred or was discovered.

State and regional QE Unit staff and division behavior analysts aggregate event (EMT) data quarterly to further identify patterns and trends. Division behavior analysts conduct further analysis if trends or patterns of overuse, unauthorized use and/or ineffective use are noted.

Every two years a review by L&C staff of personnel records is completed as a component of the certification process to assure all staff have received the needed training regarding the individual plan, the basic concepts of Positive Behavior Support, and an approved physical crisis management system such as MANDT or CPI, if restraint is used for the individuals supported by the provider. The L&C staff also reviews policies and procedures for compliance with state requirements.

Providers who are placed on conditional certification status are reported to MHD as it occurs. Any contract termination is reported to MHD as it occurs.

Appendix G: Participant Safeguards

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

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

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

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

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

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in

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

Restrictive interventions may be utilized when a need for such a procedure is identified and described in an individual's ISP or BSP that is a specialized part of the individual's support plan written by a licensed behavioral provider. Relevant needs are situations in which the individual has frequently engaged in harmful behaviors and less restrictive procedures have not been successful, or as part of a legal arrangement such as when a person with sexual charges has been required to avoid certain public areas.

Through requirements of the waiver service definitions and provider contracts staff are required to be trained on the individual's ISP, BSP, and crisis/safety plan prior to implementing any individual restrictive interventions. Any staff utilizing restrictive interventions involving physical holds is required to be trained and competency-tested in MANDT or CPI or other Division-approved physical crisis management system.

Any limitations or interventions imposed with regard to the restriction of participant movement, participant access to others, locations or activities, and restriction of participant rights must be reviewed by DD State Responsible Oversight Organization or the approved Due Process Review Committee and documented in the individual's plan.

The state does not allow the use of:
Physical restraint techniques that interfere with breathing; or any strategy in which a pillow, blanket, or other item is used to cover the individual's face as part of a reactive strategy;
• Prone restraints (on stomach), restraints positioning the person on their back supine, or restraint against a wall or object;
• Restraints which involve staff lying/sitting on top of a person;
• Restraints that use the hyperextension of joints;
• Any technique which has not been approved by the Division, or for which the person implementing has not received Division-approved training;
Any reactive strategy that may exacerbate a known medical or physical condition, or endanger the individual's life, or is otherwise contraindicated for the individual by medical or professional evaluation;
• Containment without continuous monitoring and documentation of vital signs and status with respect to release criteria;
• Use of any reactive strategy on a "PRN" i.e., "as required" basis. Identification of safe procedures for use during a crisis in an individual's safety crisis plan shall not be considered approval for a restraint procedure on an as-needed basis;
• Aversive stimuli;
• Any procedure used as punishment, for staff convenience, or as a substitute for engagement, active treatment or behavior support services;
• Inclusion of a reactive strategy as part of a behavior support plan for the reduction or elimination of a behavior;
• Reactive strategy techniques administered by other persons who are being supported by the agency;
• Corporal punishment or use of aversive conditioning such as, but not limited to applying painful stimuli as a penalty for certain behavior, or as a behavior modification technique;
• Overcorrection by requiring the performance of repetitive behavior. Examples include, but are not limited to: Contingent exercise, writing sentences, over-cleaning an area, repeatedly walking down a hallway after running;
• Placing persons in totally enclosed cribs or barred enclosures other than crib; and
• Any treatment, procedure, technique or process prohibited by federal or state laws.

Less restrictive techniques, such as de-escalation, discussion, re-direction, for example, must be attempted before implementing any restrictions. Missouri State Statute outlines consumer rights and communication of any restrictions of those rights. If necessary for the individual's habilitation or therapeutic care, visitors, phone calls, clothing choices, carrying money on their person, television programming or reading materials and outdoor recreation may be restricted. The participant and guardian must be included and informed; and the criteria for removing any restrictions and timelines for reviewing must be documented in the individual's plan. For each episode in which restrictive interventions as outlined in the plan are implemented the following must be documented in the daily observation note: the circumstances and the situation, the less restrictive measures that were attempted, and the implementation of the restrictive intervention. Any restrictions are required to be reviewed by Regional Office/ State Operated Waiver Provider or authorized Due Process Review Committee.

The Regional Behavior Support Review Committee will approve or deny restrictive procedures that are presented to the committee. The Behavior Support Review Committee will review the ISP and BSP to determine that least restrictive practices are being followed to ensure best behavior support practice. The review process includes teaching practices to develop alternative skills, fading of restrictive supports, and review of data toward progress to work toward elimination of the restriction. Additionally, the ISP and BSP must be reviewed by an approved Due Process committee in the region to evaluate that due process has been afforded the individual, the guardian or individual must consent to the use of the restrictive intervention, there must be an identified strategy for elimination of the restrictions and regular review of the progress towards this. This review would occur prior to utilizing the restrictive interventions and at least annually thereafter at the time of the annual plan development.

Any participant who has a grievance regarding their rights or a complaint may contact the DMH, OCS through the toll-free telephone line, through a dedicated e-mail address or by letter.

Any of the Division's quality management functions may identify unauthorized use of restrictive interventions.

The use of restrictive procedures that have not been identified in the ISP or BSP and have not been evaluated in the Due Process committee might be identified through the Support Coordination monitoring process, L&C survey process, the incident report review process in a regional office or through reporting by the individual, guardian, or other person.

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

Any of the Division's quality management functions may identify unauthorized use, overuse of inappropriate use of restrictive interventions.

The use of restrictive procedures that have not been identified in the ISP or BSP and have not been evaluated in the Due Process committee might be identified through the Support Coordination monitoring process, L&C survey process, the incident report review process in a regional office or through reporting by the individual, guardian, or other person.

The operating agency is responsible for the oversight of the state's DMH event management system EMT. All reported events are entered into the DMH Event management tracking system in EMT.

Support coordinators shall have the data from the event report for personal planning purposes. Information surrounding individual issues such as restrictive procedures are reviewed and discussed by the interdisciplinary team to ensure that safeguards for the individual are followed and that due process has occurred. The TCM TACs conduct the oversight to ensure the safeguards are occurring.

Support coordinators conduct quarterly reviews of the support plan.

The State agency is responsible for overseeing the use of restrictive interventions and ensuring that state safeguards concerning their use are followed.

State and regional QE Unit staff and division behavior analysts aggregate event (EMT) data quarterly to further identify patterns and trends. Division behavior analysts conduct further analysis if trends or patterns of overuse, unauthorized use and/or ineffective use are noted.

Data reported related to restricted procedures is aggregated specific to the participant. The data, upon aggregation, is analyzed and discussed by the interdisciplinary team to ensure that safeguards for the individual are followed and any necessary strategies are implemented to prevent re-occurrence.

Any participant who has a grievance regarding their rights or a complaint may contact the DMH, OCS through the toll-free telephone line, through a dedicated e-mail address or by letter.

Appendix G: Participant Safeguards

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

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

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

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

Reporting is governed by Missouri administrative rules, known as CSR. The Regional Office/ State Operated Waiver Provider reviews the event report and may identify the use of an unauthorized use of seclusion. The support coordinator could also discover an unauthorized use of seclusion through review of the event summary or Service Monitoring (i.e. in conversation with the individual/staff, review of progress notes, etc.). The special review process will be instituted whenever use of seclusion or time out is reported or discovered as outlined in 9 CSR 45-3.090 Behavior Supports.
If use of prohibited or unauthorized procedures are discovered, the following occurs:
(A) Regional Director is notified of the use of prohibited procedures, the agency involved, persons for whom the procedures were utilized, and reasons for use;
(B) Regional Director directs regional staff and Area Behavior Analyst to conduct a focused review of the agency;
(C) If the focused review confirms that prohibited or unauthorized procedures were used, the Regional Office Director will be informed and notify the provider and support coordinator;
(D) Area Behavior Analyst works with planning teams to determine appropriateness of strategies and need for additional services to assist the provider to address the situations positively, proactively and preventatively;
(E) Area Behavior Analyst refers supports of individuals, for whom the prohibited practices have been used, to the RBSRC; and
(F) Follow up reviews of the provider will occur, to ensure that appropriate procedures and supports are utilized and prohibited practices have been discontinued, for a duration determined by the Chief Behavior Analyst.

○ **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.

The entities that have ongoing responsibility for monitoring participant medication regimens include the prescribing entities, contracted provider for residential services, and the Missouri Division of DD.

The responsibility for monitoring a participants medication regimen incorporates activities at three levels of service delivery.

The monitoring of a participants medication regimen starts with the participant's primary care provider who coordinates and prescribes their care and at least annually should be evaluating all prescribed medication and treatment regimens.
The contracted service provider is required to provide Residential Nursing Oversight service for all recipients of residential services. The contracted service provider is also responsible for reporting medication errors to the Division in accordance with Directive 4.070, Event Reporting Process.
Nursing oversight shall be provided by RNs licensed and in good standing in the state of Missouri.

The Residential RN is responsible to provide oversight of the medication administration program or processes including but not limited to:

a. Continuous oversight of proper medication storage, handling, and administration procedures and techniques;
b. Continuous evaluation of all delegated nursing tasks including medication administration;
c. Monthly monitoring of an individual's medication administration record and physician orders for adherence to their prescribed medication regimen;
d. Monthly monitoring of the individual's response to their prescribed medication regimen including monitoring of adverse reactions and completion of related lab monitoring.
e. Monthly review and analysis of event reports for medication errors and injuries; and
f. Completion of a Monthly Health Summary reflecting the nurse's clinical analysis of the above activities for each consumer.

The Division of DD QE RN's monitor the participants medication regimen through the following activities:
• Monitoring of daily reports containing reportable medication error events. As defined by the Division, mediation errors may result in clinical reviews conducted by Division QE RN's for risk mitigation.
o Each reported medication of error regardless medication type, if classified as moderate or severe receives a Clinical/QE Review conducted by the DD QE RN. Moderate medication errors are errors which result in treatment and/or interventions in addition to monitoring or observation. Serious classifications are errors which are life threatening and/or have permanent adverse consequences. The state will follow the process of additional inquiry into the event if it is suspected that the staff responsible for making the error did something or failed to do something which put the individual in imminent danger to the health, safety, or welfare of an individual or substantial probability that death or serious physical injury would result. If following the additional inquiry and the findings meet criteria for reasonable cause for suspicion of abuse or neglect, the event will be referred to the DMH investigation unit.

o The Clinical/QE Review evaluates contributing factors to the medication error which may result in a Plan of Action to minimize the potential reoccurrence of future medication errors.

• Monitoring medication regimen as part of the Division's QE function for health and safety monitoring for participants in receipt of residential services. This residential participant screening occurs annually, with significant health changes, and when entering placement for the first time.

• Quarterly analysis of medication error data by regional quality units for individual and system improvement strategies which may result in individual, provider, regional plans of action .

The Division monitors on a quarterly basis for use of Psychotropic and Antipsychotic medications. The Division monitors for individuals identified through Medicaid claims billing where individuals are in receipt of 5 or more Psychotropic and/or 2 or more Antipsychotic Medications. Individuals identified as meeting this threshold are tracked in a SharePoint database .

Quarterly the State QE Unit reviews the medication error data to ensure that qualifying individuals received appropriate clinical reviews and

The Division is transitioning their Health Mentoring Process and Screening Instrument from Health Identification & Planning System (HIPS) to the MO Health Risk (HRS) Screening Process. Within the Health Risk Screening tool, the participants medication regimen will be screened for contraindications and will identify any recommended health screenings and monitoring for follow up by the provider's nurse and planning team. The utilization of this process will be fully implemented with all waiver participants by March of 2024.

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

The agency responsible for oversight is the MO DMH /Division of DD (operating agency). The operating agency monitors medication administration through the Division's Quality Functions for discovery, remediation, and quality improvement.

As part of the Division's EMT process, all medication errors that reach the individual are required to be reported to the Regional Office/ State Operated Waiver Provider. A clinical review is completed by a QE RN for all medication errors meeting the division definition of moderate or severe. All clinical review findings and actions are recorded in the EMT system. The clinical review is a form of risk mitigation, reducing risk factors associated with the event.
Medication errors where there is a suspicion of abuse, neglect, and/or misuse of funds meeting the criteria for reasonable cause are submitted to the DMH Central Investigations Unit for investigation.

During monitoring visits, support coordinators are expected to review documentation to assure all prescribed medications are administered, discovered errors are reported, and adequate supplies of medications are available.

The Division monitors on a quarterly basis for use of Psychotropic and Antipsychotic medications. The Division monitors for individuals identified through Medicaid claims billing where individuals are in receipt of 5 or more Psychotropic and/or 2 or more Antipsychotic Medications. Individuals identified as meeting this threshold are tracked in a SharePoint database.

Quarterly the State QE Unit reviews the medication error data for analysis and system improvement strategies which may result in individual, provider, regional or state plans of action.

Each reported medication of error regardless of medication type, if classified as moderate or severe receives a Clinical/QE Review conducted by the DD facility QE RN. Moderate medication errors are errors which result in treatment and/or interventions in addition to monitoring or observation. Serious classifications are errors which are life threatening and/or have permanent adverse consequences. The state will follow the process of additional inquiry into the event if it is suspected that the staff responsible for making the error did something or failed to do something which put the individual in imminent danger to the health, safety, or welfare of an individual or substantial probability that death or serious physical injury would result. If following the additional inquiry and the findings meet criteria for reasonable cause for suspicion of abuse or neglect, the event will be referred to the DMH investigation unit.

The Clinical/QE Review evaluates contributing factors to the medication error which may result in a Plan of Action to minimize the potential reoccurrence of future medication errors.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

◉ **Waiver providers are responsible for the administration of medications to waiver participants who**

cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

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

In accordance with 9 CSR 45-3.070, staff who administer medication or supervise self-administration of medication to participants must be either a licensed physician; licensed nurse; or must be delegated the task of medication administration and supervised by a licensed medical professional. Persons who administer or supervise self- administration of medication to participants must be certified as a Medication Aide through DMH or DHSS before being delegated and performing medication administration tasks.

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

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

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

In addition to appropriate follow up with medical professionals in response to medication errors, providers are responsible for documenting and reporting medication errors to their designated State Division of DD Regional Office in accordance with Event Reporting regulation 9 CSR10-5.206. In addition, any action taken should be reported. Event reports are entered into the statewide EMT data base.

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

In accordance with 9 CSR 10-5.206 Report of Events, providers are required to record any of the following medication errors;
- Failure to administer;
- Wrong Dose;
- Wrong Medication;
- Wrong Route;
- Wrong Person;
- Wrong Time

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

In accordance with 9 CSR 10-5.206 Report of Events, providers are required to report medication errors meeting the policy definitions of: In accordance with 9 CSR 10-5.206 Report of Events, providers are required to report any of the following medication error types that reach an individual;
- Failure to administer;
- Wrong Dose;
- Wrong Medication;
- Wrong Route;
- Wrong Person;
- Wrong Time

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

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

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

Oversight is conducted by the operating agency, Division of DD. In accordance with 9 CSR 10-5.206, medication errors are reported to the Regional Office/ State Operated Waiver Provider using the standardized Event Report form. These reports are entered into the statewide event database (EMT) and are tracked for analysis of trends and patterns at the provider, consumer, regional, and state level. Division of DD QE RNs also review medication error event reports to identify patterns or trends for consumers and/or providers. The reports are also reviewed to ensure appropriate safeguard measures were taken.

If medication errors are noted in the records, the support coordinator may investigate further to ensure the errors were properly reported to the state in accordance with 9 CSR 10-5.206 and that all necessary corrective action was taken.

Quarterly the Division of DD's State QE Unit analyzes data to identify trends or patterns that may require additional actions for the provider, the region, or statewide.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number of participant records that document the participant has been informed of how to report suspected abuse/neglect/misuse of funds. (Number of participant records that document the participant has been informed of how to report suspected abuse/neglect/misuse of funds divided by the number of participant records reviewed

within the identified timeframe.)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
 # & % of unexpected deaths meeting criteria for a DD Mortality Review, closed at the Division level with a closed plan of action(# & % of unexpected deaths meeting criteria for a DD Mortality Review, closed at the Division level with a closed plan of action divided by # of unexpected deaths meeting criteria for a DD Mortality review closed at the Division level with a plan of action identified)

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of EMT system events with a complaint or suspicion of abuse, neglect, misuse of funds or property, reported in the required timeframes (Number of events with a complaint or suspicion of abuse, neglect, misuse of funds or property reported in the required timeframes divided by Number of events with a complaint or suspicion of abuse, neglect, and/or misuse of funds or property)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of EMT system events where an inquiry was conducted within required timeframes (Number of EMT system events within the identified quarter where an inquiry was conducted within required timeframes divided by Number of EMT system events within the identified quarter where an inquiry was conducted.)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of EMT system events where an investigation was initiated within required timeframes. (Number of EMT system events where an investigation was initiated within required timeframes divided by Number of EMT system events where an investigation was initiated)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of moderate or severe med errors with a closed clinical QE review (Number of moderate and severe med errors from EMT with a closed clinical QE review divided by Number of moderate and severe med errors from EMT)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of choking events with a closed clinical QE review (Number of choking events entered in EMT with a closed clinical QE review divided by Number of choking events entered in EMT)

Data Source (Select one):
Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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:
The number and percent of individuals who did not experience a reported event indicating a prohibited procedure. (The total # of individuals who did not have a reported event where a prohibited procedure was identified divided by the total number individuals in the waiver)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of individuals who did not experience a reported event

indicating the use of an emergency procedure. (The total # of individuals who did not have a reported event where an emergency procedure was identified used divided by the total number individuals in the waiver)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
The number and percent of individuals who were afforded due process for a restrictive intervention. (The number of individuals who were afforded due process for a restrictive intervention divided by total number who were referred for due process for a restrictive intervention.)

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

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

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

Data Aggregation and Analysis:

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

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:
Individuals have completed Health Risk Support Plans (HRSP) in accordance with the annual Health Risk Screening process. (Individuals with completed Health Risk Support Plan (HRSP) in accordance with the annual Health Risk Screening process divided by the Number of individuals meeting the criteria for a HRSP)

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

All events entered into the EMT system require an electronic review be conducted by designated DD facility staff. Upon review of events entered into the EMT system individual problems may be discovered. When individual problems are discovered the designated DD facility staff conducting the event review will notify appropriate DD staff who will conduct further review to address the individual problem. The nature of the individual problem will determine what DD staff is responsible for addressing the issue. If further follow up is required, remediation of the individual problem is documented at the facility level and monitored through quarterly reviews at the state division level.

Remediation may be a coordinated effort by DD central office staff, DD facility staff, contracted provider, the person's planning team and other concerned parties which may include law enforcement or other state Departments. The state routinely monitors and evaluates events to ensure all individual problems have been reviewed.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 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.

Overview: The Division's quality management strategy includes multiple real-time methods of feedback and information gathering in addition to periodic inspection processes. Individuals (program participants) and community members are in active roles. The system utilizes quality improvement processes such as data analysis, tracking, and trending. Data bases are in place for gathering information and subsequent analysis and trending.
In addition to the statewide quality management functions completed by the Division of DD, there are functions completed by the DMH and other state agencies including DSS/MHD, the Medicaid administrative agency. Each quality management function has its own guidelines, designated implementation staff, and process of identification, communication, and remediation. This allows for timely evaluation of information and development of an appropriate action plan for the individual issue(s) identified. Systems improvement efforts are based upon the consolidation and analysis of data from all functions, as well as other information.
The following are the identified quality functions performed by the Division of DD.
Participant-Centered Service Planning and Delivery
Division Directive 3.020, Individual Support Plan Monitoring and Review, prescribes monitoring standards for services funded through DMH/DD. This directive describes the frequency of monitoring visits/contacts for services, service areas to be reviewed, documentation, and process for identification, communication, and resolution of issues. Support Coordinators enter all service monitoring findings into the IQMFD Database (formerly APTS).
Provider Capacity and Capabilities
Licensure & Certification
Licensure and Certification (L&C) Missouri Code of State Regulations (9CSR45-5.060) outline the certification process, which includes a biennial review of health, safety, and legal rights deficiencies discovered from L&C are entered into the IQMFD database.
DMH contract process ensures providers are qualified to provide the services they propose to deliver. Providers must keep their credentials current and maintain a current POS waiver contract with DMH in order to continue as an active waiver provider. The DMH contract covers financial responsibility, quality of care, and the provider's obligation to protect the health, safety and human rights of consumers.
Provider Relations Review
Division Guideline #55 prescribes the functions of Provider Relations as it relates to the review of contracted providers with the DMH/DD to ensure consistent application across the state and to develop partnerships that enhance the overall quality of services delivered. Provider Relations staff work with contractors to ensure service delivery is consistent with best practices, State Rules, Medicaid waiver guidelines and DMH contract and policy.
Participant Safeguards
Fiscal Review
The Missouri Medicaid Audit and Compliance Unit (MMAC), established within the Department of Social Services provide oversight, audit and compliance of Missouri Medicaid Program providers and participants. Findings from MMAC are sent to Regional Offices and are entered into the IQMFD Database.
The Division of DD conducts a purchase of service and individual funds review in accordance with Division Directive 5.070. The purpose of the review is to ensure all benefits and other individuals' funds managed by a Regional Office or contract provider are appropriately utilized to meet the needs, wants and desires of the individual. The review also ensures services authorized under the POS program and funds paid via general revenue to contract providers are provided and paid in accordance with the POS service requirements.
Service Monitoring
Division Directive 3.020 prescribes monitoring standards for services funded through DMH/DD. This directive describes the frequency of monitoring visits/contacts for services, service areas to be reviewed, documentation, and process for identification, communication, and resolution of issues. All service monitoring findings from private TCM agencies are now directly entered into the IQMFD Database.
Event Report Processing
Division Directive 4.070 prescribes criteria and procedures for reporting events affecting consumers in residential facilities, day programs or a specialized service that is licensed, certified, accredited or funded by the Division of DD.
Department Guideline #69 prescribes the procedures for accepting, reviewing and conducting follow up to event reports, which meet criteria for entry into the Division of DD Information System-EMT system as outlined in Division Directive 4.070.
Division of DD Information System Event Management Tracking collects data related to incidents events and medication errors in community services, as outlined in CSR 10-5.200 & 206 & Division Directive 4.070. This system also maintains the data for deaths and investigations for abuse, neglect or misuse of consumer funds.
Regional QE teams, State QE Leadership Team, and DMH Investigations Unit are responsible for managing and

tracking the data in the system.
Division Guideline #68 describes the Regional Office Inquiry Process. The intent of the guideline and policy is to prescribe the structural consistency needed for conducting Division Regional Office inquiries when there is a complaint, suspicion or allegation of Abuse/Neglect/Misuse of Consumer Funds & Property.
Complaint Response Process
Division guideline #75 prescribes the structural consistency needed for receiving, reviewing and responding to complaints (Contacts) received by the DMH Office of Constituent Services (OGS). The purpose of the Office of Constituent Services is to ensure that individual rights are not being violated; to review reports of abuse or neglect; and to provide useful information to constituents and family members about mental health issues. This guideline outlines the DD response process required for follow up action and documentation; ensuring that all issues of the complaint have been addressed by DMH/DD. The DMH/DD Consumer Safety Coordinator and the Office of Constituent Services are responsible for managing, tracking, and trending the data in the Division of DD Information System-EMT.
Mortality Review
Division Directive 3.070 prescribes procedures to be followed for notification and reviewing of deaths of individuals served by DMH/DD.
Quality of Services Review
The Quality of Services Review, as described in Division Guideline #54,prescribes a standardized procedure to ensure the individual has full access to benefits of community living and the opportunity to receive services in the most appropriate integrated setting.
Participant Rights and Responsibilities
Due Process (Human Rights) Committee –9 CSR 45-3.090 Behavior Supports describes the functions and roles of the Due Process (Human Rights) Committee in reviewing and assuring due process has occurred when there is a proposal for any restriction or limitation of a person's rights. All Committee meetings and findings are tracked in a statewide tracking system.
Participant Outcomes and Satisfaction
National Core Indicators (NCI)
DMH/DD continues to participate in the NCI initiative which includes a consumer survey and family surveys. NCI measures system performance and consumer satisfaction and compares this performance with the other participating states and national averages. The findings from surveys are shared with stakeholders and DMH/DD staff. Information obtained from the NCI survey is utilized by the DMH/DD for the development of statewide quality initiatives.
Data for trending, prioritizing, remediating and implementing system improvements is continually collected through the identified quality functions, entered into databases, and analyzed/reported at designated intervals in accordance with Division Directive 4.080. Reports are provided to Division management, regional level management and staff, providers, stakeholders, and the Medicaid agency at designated intervals, dependent upon the specified function and need. The state-wide QE Leadership Team provides the oversight, management and evaluation of the quality improvement processes/strategy for the Division of DD.
Reports are shared with the Quality Advisory Council, a group of self-advocates and family members or guardians. The Quality Advisory Council represents a cross-section of advocacy groups, family members, consumers and public guardians. The Council reviews a wide variety of information from waiver performance, NCI, all quality integrated functions, current grants and Division initiatives.
The process for trending is grounded in the CMS waiver quality assurances. Data is aggregated and reported state-wide, by individual region, and, at the regional level, by provider and consumer. The state QE Leadership Team tracks and evaluates remediation at the regional or state level for identified trends.
Process for Trending:
The state QE Leadership team analyzes and reports information to senior Division management and regional directors from service monitoring, service reviews, LOC, incident/injury, and abuse/neglect quarterly. These reports include summarizing performance in the identified areas, describing any patterns/trends, and discussing actions needed. These reports aggregate data state-wide and also aggregate by region. If trends are noted to occur within specific regions or with certain contracted providers, the Division of DD Statewide QE Team notifies Regional Office QE staff of the concerns to be addressed locally.
Performance measures as outlined in each of the waiver quality assurances are analyzed and reported by state QE staff to the state Medicaid agency (the MHD) quarterly. In addition to the written reports, the DD Federal Programs Unit, DD QE staff and the MHD meet quarterly to review the data reports/trends specific to each waiver and discuss other issues pertinent to the performance measures and the operation of the waivers.
When the Quality Improvement Strategy (QIS) spans more than one waiver information is stratified for each

waiver. The sampling methodology is based upon a representative sample for each waiver and the QIS is reported in Appendix H for each waiver. QIS may span more than one waiver and is dependent upon the quarterly analysis of the data related to each specific performance measure. The majority of the performance measures for the four division operational HCBS waivers (MO.0178, MO.0404, MO.0841 and MO.40185) are consistent in what is being measured to meet a specific assurance and therefore QIS may impact all applicable waivers. There may be instances where a specific QIS is targeted to a particular waiver if performance is at or below 87.0%. No other long-term care services are addressed in the QIS.

Implementation of system improvements:

When patterns or trends are identified from the data and the reviews mentioned above, further analysis is conducted by the QE Leadership Team along with stakeholders who are involved in the identified trends. Work groups may then be developed to determine what systems improvement strategies could be developed to impact the areas identified.

Changes in rules, policy, and contracts are drafted and distributed to allow feedback from stakeholders. Once finalized, changes are distributed to Division DD's staff and contracted providers. Discussions are held at local provider meetings, as well as statewide coalitions of providers to assure that changes are understood and implementation dates are communicated. Any training required to assist with the implementation of these changes are initially planned and coordinated by process leads and then assumed by regional office staff. The implementation of system improvements is analyzed for effectiveness of remediation through periodic reviews, and through ongoing analysis of related data.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The state QE Leadership team analyzes and reports information to senior Division management and regional directors from service monitoring, service reviews, LOC, incident/injury, and abuse/neglect quarterly in accordance with Directive 4.080. These reports include summarizing performance in the identified areas, describing any patterns/trends, and discussing actions needed.

Regional staff review all integrated function databases for trends in service monitoring, incident/injury/abuse/neglect, remediation for service plan reviews, provider relations reviews, and QE reviews in their specific region to identify any significant patterns, trends, or concerns. These reports summarize regional trends for waiver and non-waiver services, specific provider issues and specific consumer issues. Each region develops reports on identified trends to be addressed locally with community providers and the Regional Offices.

Performance measures as outlined in each of the waiver quality assurances are analyzed and reported by state QE staff to the state Medicaid agency (the MHD) quarterly. In addition to the written reports, the DD Federal Programs Unit, DD QE staff and the MHD meet quarterly to review the data reports/trends specific to each waiver and discuss other issues pertinent to the performance measures and the operation of the waivers.

When the Quality Improvement Strategy (QIS) spans more than one waiver information is stratified for each waiver. The sampling methodology is based upon a representative sample for each waiver and the QIS is reported in Appendix H for each waiver. QIS may span more than one waiver and is dependent upon the quarterly analysis of the data related to each specific performance measure. The majority of the performance measures for the four division operational HCBS waivers (MO.0178, MO.0404, MO.0841 and MO.40185) are consistent in what is being measured to meet a specific assurance and therefore QIS may impact all applicable waivers. There may be instances where a specific QIS is targeted to a particular waiver if performance is at or below 87%. No other long-term care services are addressed in the QIS.

Implementation of system improvements:
When patterns or trends are identified from the data and the reviews mentioned above, further analysis is conducted by the QE Leadership Team along with stakeholders who are involved in the identified trends. Work groups may then be developed to determine what systems improvement strategies could be developed to impact the areas identified. Sometimes this process results in policy/procedure changes, technical assistance with providers or private TCM entities, training with state staff, or it could be in the form of an awareness campaign to bring a more heightened attention to the identified situation.

Changes in rules, policy, and contracts are drafted and distributed to allow feedback from stakeholders. Once finalized, changes are distributed to Division DD's staff and contracted providers. Discussions are held at local provider meetings, as well as statewide coalitions of providers to assure that changes are understood and implementation dates are communicated. Any training required to assist with the implementation of these changes are initially planned and coordinated by the QE Leadership Team and then assumed by regional office staff. The implementation of system improvements is analyzed for effectiveness of remediation through periodic reviews, and through ongoing analysis of related data.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

There are several points at which the QIS is evaluated. As data is reported at the identified intervals, data integrity and fidelity of the review processes are also evaluated. This allows an opportunity to impact design of the quality strategy, discovery processes, remediation effectiveness and methods, and prioritizing for systems improvement.

Each quarter at both the regional and state level, the results of the discovery processes are reported in accordance with Division Directive 4.080. This is also an opportunity to note changes, trends, and to identify if those trends indicate a need for updating the QIS.

On an annual basis, the QIS is evaluated and summarized in the annual report. When changes are needed, objectives are outlined and strategies to meet those objectives are identified and assigned. The information is presented to Division of DD management.

Appendix 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):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

a) Requirements concerning the independent audit of provider agencies:

Contract providers that provide services to individuals who participate in 1915(c) waivers administered by the Division of Developmental Disabilities (DD) are not considered sub-recipients as defined in 2 CFR 200.330 since they do not have responsibility for determining program and service eligibility and they do not make programmatic decisions.

Division of DD contract providers that expend $750,000 or more in federal grant funds received from the Department are required by the Department of Mental Health (DMH) contract to have an annual audit conducted in accordance with 2 CFR 200.501.
Expenditures for this waiver are subject to the State of Missouri Single Audit conducted by the Missouri State Auditor's Office. Audits may be conducted by the Audit Services Unit of the DMH upon request. Audits may be requested by the Director of the DMH or the Director of the Division of DD based upon monitoring results, recommendations from regional offices, reports from provider staff, reports from the general public, etc.

b) As per the MOU between the DMH and the Department of Social Services (DSS) effective September 2011 there is a Medicaid Audit and Compliance Unit (MMAC) within DSS which directly manages and administers Medicaid program integrity, audit and compliance, and Medicaid provider contracts. The Division of DD is the division within DMH responsible for provision of services to individuals with DD. Division of DD provides TCM and waiver services as part of their service delivery. MMAC and Division of DD work in conjunction with regard to assuring program integrity, audit and compliance for Medicaid services. More specifically MMAC conducts provider reviews to ensure provider qualifications and services rendered in accordance and compliance with the Medicaid Program, the service plan, waiver services program, and all applicable federal and state laws and regulations. MMAC will also conduct internal audits of Division of DD enrolled Medicaid waiver providers to ensure payments comply with home and community based waiver assurances.

c) Agency (or agencies) responsible for conducting the financial audit program:

1. *The DSS MMAC reviews a sample of waiver provider billings and conducts compliance audits, annually, in which documentation of services provided is reviewed to ensure services are in compliance with policies/regulations, service billed to MO HealthNet (MHD) were provided, and services were documented as required; the MMIS includes edits to ensure appropriate payments.*

MMAC utilizes both on-site and desk reviews. Providers are selected based on complaints, referrals, exception reports, direction from supervisor, or geographical area. Multiple factors contribute to whether an on-site or desk review is conducted. A desk review could escalate into an on-site review if there is difficulty getting the requested records from the provider or depending on the preliminary results of the desk review.

MMAC reviews many items to ensure services were rendered including but not limited to progress notes, employee time sheets, staffing patterns, and attendance records. MMAC also reviews the ISP and any exception approvals needed for any items exceeding the cost limits, which would explain the need for the service to be approved and why the limit was exceeded. MMAC also reviews budgets that are approved and based on waivers, we may question why cost limits were approved to be exceeded.

There are several ways of determining fraudulent billing activities. We compare staff timesheets with other places of employment for staff, investigative reports completed by DMH indicate problem areas such as staff not being present when 24 hour care is needed, no notes present or notes do not support time or service, verbatim notes from day to day, billing for services that could not have been performed such as after date of death, staff documenting is not the staff that is working, etc. Any type of fraudulent activity is sent to an investigative unit and can then possibly be referred to the Attorney General's office for additional follow up.

MMAC furnishes copies of the review findings to both the Department of Mental Health and MO HealthNet. The DMH Office of Audit Services only performs financial audits on non-Medicaid services since the establishment of MMAC. The state auditor's annual Single State Audit includes a review of Medicaid waiver documentation, but is not specific to Partnership for Hope waiver.

Post Payment Review Sampling Methodology
1) Providers are selected for review based on complaints, referrals, exception reports, direction from supervisor, or geographical area.
2) Claims are selected for review based on abnormal billing patterns on the Truven (FADS) report, APTS reports that

may identify issues, prior DMH-DD billing reviews.
3) MMAC does not do statistical samples for Waiver services.
4) MMAC reviews approximately 30% of enrolled Waiver providers annually
5) The time period for reviews can extend back 5 years. Depending on the type of review, 3 months or a year of claims could be reviewed during an audit.

2.State Auditor's Office conducts financial audits under the Single State Audit or based on information from stakeholders.

As part of the Medicaid provider enrollment process, all waivered service providers are required to have a DMH Purchase of Service contract. The DMH serves as the billing agent on behalf of all waiver service providers since the Department maintains the prior authorization system. This process pertains to all waiver services which are all prior authorized.

The Division of DD's automated network allows support coordinators to request services identified in the individual's service plan. Before services are authorized, all new plans and plans requesting increased services must go through the regional office's Utilization Review (UR) process for approval. Approved services are input in the prior authorization system.

The Division of DD maintains an information system which included prior authorization. The provider can access the authorization system online and bill for authorized services that have been delivered. Based on the Medicaid Agency published claims processing calendar, the claim data and any adjustments are approved by DMH central office and submitted to the Medicaid Agency's fiscal agent for processing.

Claims are submitted electronically to the MO HealthNet fiscal agent and are subjected to appropriate edits in the MMIS system to ensure that payment is made only on behalf of those clients who are Medicaid eligible, and to providers who are enrolled, on the date a service was delivered. The provider subsequently receives payment directly from the Medicaid Agency as reimbursement for services rendered. A remittance advice indicating the disposition of billed services accompanies the provider's reimbursement.

The audit trail consists of electronic encounter documentation and claims data located in the Division of DD information system, MHD, and with the provider of service. The Division of DD regional offices and contracted TCM entities maintain the individual service plan. The Division of DD also maintains billed claim data for all claims submitted to the MHD, Medicaid remittance advices, and a history of authorized and paid services by fiscal year. The information collected and maintained by the Medicaid agency's MMIS system includes: copies of all paid and denied claims; Medicaid remittance advices; and eligibility information on each individual served.

Providers are required to maintain financial records and service documentation on each person served in the waiver including the name of the participant, the participant's Medicaid identification number, the name of the individual provider who delivered the service, the date that the service was rendered, the units of service provided, the place of service, attendance and census data collection, progress notes and monthly summaries.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the 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 paid claims for individuals enrolled in the waiver with the appropriate waiver modifier(Number and percent of paid claims for individuals enrolled in the waiver with the appropriate waiver modifier divided by number and percent of paid claims for individuals enrolled in the waiver)

Data Source *(Select one):*
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*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of waiver service claims paid that did not exceed the maximum allowable rate (Number of paid waiver service claims by procedure code that did not exceed the maximum reimbursement allowance divided by total number of paid waiver service claims)

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 *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of initial and amended waiver contracts implemented with the rate methodology described in the waiver (Number of initial and amended waiver contracts implemented with the rate methodology described in the waiver divided by Number of initial and amended waiver contracts implemented)

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other***	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

1. All waiver services are prior authorized. All approved waiver services for waiver-enrolled persons are input into the prior authorization system in Division of DD Information System. DMH serves as the billing agent on behalf of all waiver service providers since DMH maintains the prior authorization system. The automated prior authorization system creates claims that are submitted electronically to the MHD fiscal agent and subject to the appropriate edits in MMIS to include persons were Medicaid eligible and providers were actively enrolled with MO HealthNet on date of service.
2. Prior authorized services include the rate that is authorized. Only the amount authorized can be paid.
3. Payment is not made through the MMIS unless a valid waiver procedure code has been authorized and billed.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the 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.*

1) For performance measure I.i.a.i.1, any claims billed to MO HealthNet that are not covered waiver services will be adjusted so that reimbursement is returned to MO HealthNet.
2) Performance measure I.i.a.i.2 involves tracking on a quarterly basis to ensure paid claims for an individual service recipient are applied to the waiver with which he or she is enrolled on each date of service. This is verified by comparing the date of service and eligible dates for the individual in receipt of the waiver. Any service claims paid for the individual outside of the eligibility dates will be returned to MO HealthNet.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Each Division of DD regional office has Provider Relations staff assigned to work with Division of DD waiver providers. The Division of DD is responsible for rate development. The rate methodology for each group of services is described below. A maximum allowable for each service is calculated and is applied across all areas of the State. All maximum allowable rates are approved by the MHD. Service rates may be adjusted prospectively based on State budget appropriations.

Rates are developed for each waiver service using one of the following rate methodologies:
1. The fee schedule methodology is utilized for the following services: day habilitation — behavioral, day habilitation — medical, ABAs, supported employment, prevocational, job development, career planning, benefits planning, and family peer support. One statewide fee schedule rate is developed for each service and paid to all providers.

To develop the fee schedule rates, the following key cost components were considered for each service:
A. Staff wages
B. Employee benefits and other employee-related expenses
C. Productivity
D. Other service-related expenses
E. Administrative expenses

To model the cost components, various market data sources were reviewed including Bureau of Labor Statistics, Missouri-specific staff wages and Missouri-specific health exchange costs. The market assumptions for each cost component were factored together to develop an overall hourly rate, which was then converted to a "per unit" rate using the specific unit definition for each service (e.g., per 15 minute unit).

2. The negotiated market price methodology is utilized for the following services: environmental accessibility adaptations, specialized medical equipment and supplies, assistive technology, community transition, individual directed goods and services, dental and transportation. For environmental accessibility adaptations, specialized medical equipment and supplies and assistive technology services, bids or cost estimates for a job/equipment/supply are obtained from two or more providers. The regional office reviews the quotes for reasonability and then authorizes a service price based on the provider with the lowest and best price. For community transition, dental and transportation services, a provider supplies cost information to the regional office for review and approval. For all these services, the authorized amount cannot exceed the maximum allowed rate set by the State for the service.

3. The Appropriated Fee Schedule is utilized for the following services: Day Habilitation, Community Networking, and Individualized Skill Development. Provider rates are based on actual historical state costs, which have been adjusted by appropriation passed by the Missouri General Assembly specifically to raise the lowest rates to a minimum fee schedule across all providers to stabilize provider capacity. Rates are adjusted as cost of living funds are appropriated.

4. The self-directed methodology is used for the following services: self-directed personal assistance, self-directed medical personal assistance and team collaboration personal assistance. Employers (families, individuals, guardians) are given a budget based on the necessary hours determined for the individual and the statewide average rate for agency personal assistance. The employer sets the actual wage of the direct care staff based on their budget authority and must stay within the budget. The per unit cost cannot exceed the maximum allowable rate set by the State.

5. Professional Services such as personal assistant, personal assistant-group, personal assistant – medical, professional assessment and monitoring, person centered strategies consultation, physical therapy, occupational therapy, speech therapy, support broker, community specialist, and temporary residential reimbursement rates were established based on cost components that a provider would incur to deliver the service, including the expertise required of the professional/semi-professional and are comparable to rates that exist for similar services with comparable requirements. Person Centered Strategies Consultation waiver services will end effective 03/01/2021.

The State re-examines rates at least once every five years, upon renewal of its waivers. Methods for reviewing rates include periodic market surveys, cost analysis and price comparison. At any time during the five-year period, re-evaluation of pricing and rate increases are considered as warranted based upon provider inquiries, service access and budgetary considerations. DDD monitors the number of providers delivering each waiver service, reviews participant complaints regarding ability to select/find a qualified provider, and considers participant feedback on service quality. Rate increases are determined by the State based on the outcomes of the periodic rate reviews performed by the State and available budget appropriations.

Individuals, providers, and other stakeholders have an opportunity to make public comments to the Division of DD, the MHD, and elected officials on rates and methodology for rate setting during annual legislative hearings in preparation for the appropriation process. Many of the Medicaid maximum allowable rates have been adjusted over the years for Cost of Living Adjustment (COLA) funding appropriated by the General Assembly. Individual rates may be adjusted for market or programmatic changes. For waiver submissions that impact rates, interested parties are notified by email blasts, online postings, postings in Regional Offices, and newspaper advertisements statewide informing of the 30 day public comment period and stakeholder forums. Additionally, providers and other stakeholders may provide comment to the Division of DD Director or DMH Director at any time regarding rates by writing a letter or during public meetings.

During the person centered planning process when service providers are selected, the participant is informed of provider rates. Individuals in all areas of the state receive services based on their needs as indicated in the ISP (person-centered service plan), regardless of the cost per unit. Also, participants are given a copy of their approved budget which contains the rate for each service they are approved to receive.

All fee schedules are located at https://apps.dss.mo.gov/fmsFeeSchedules/maindisclaimer.shtml.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The division contracts with TCM entities who may initiate the process for prior authorized services. Regional Office staff may also initiate the process for prior authorized services. The Division of DD automated customer information system allows staff of both the TCM entities and the regional offices to request prior authorization of services identified in the support plan. Before services are prior authorized, the support plan must go through the regional office or TCM entity's utilization review process if the plan is new or requests an increase in service. Final approval is performed by the Division regional offices. TCM providers are paid under State Plan for case management services and not the actual prior authorization of a service.

Since the prior authorization system resides in the DMH's information system, waiver providers are required to submit claims for services they provide through the operating agency's billing system and may not bill claims directly to MO HealthNet fiscal agent.

The automated prior authorization system creates claims that are submitted electronically to MO HealthNet fiscal agent and subject to the appropriate edits in MMIS to include persons were Medicaid eligible and providers were actively enrolled with MO HealthNet on date of service.

The ASC X12N 837 Health Care Claim format is used for billing waiver services. Claims submitted electronically are subjected to appropriate edits in the MMIS system to ensure that payment is made only on behalf of participants who are MO HealthNet eligible, and to providers who are enrolled, on the date a service was delivered. The provider receives a remittance advice indicating the disposition of billed services and any reimbursement due, directly from MO HealthNet. The Division of DD also receives copies of remittance advices since the state share paid to providers is the Department's responsibility. The Division of DD is appropriated funds for the state share of waiver service programs it administers. As claims are adjudicated in the MMIS, Division of DD delegates authority to MO HealthNet to access the funding needed payment for waiver services.

The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021 in accordance with the Good Faith Exemption granted by the Centers for Medicare and Medicaid Services.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

(a) Waiver providers must submit bills through the Division of DD information system where the prior authorizations reside. Claims must successfully process through the prior authorization system before the Department sends the claims to the MO HealthNet fiscal agent for processing through the MMIS claims processing system. There are edits within the MMIS to verify eligibility for each date of service before the system approves payment to the provider. If an individual is not eligible for any date of service, the MMIS claims processing system does not allow payment to the provider for periods of ineligibility.

(b)&(c) Billing validation to determine if services are provided is done once a year as part of the MHD's review of a sample of waiver participants. The division reviews properly paid claims ongoing with quarterly and annually data analysis.

Part of the process is to review the plan and ensure all service needs have been provided and that all services provided were included in the plan. In addition, MMAC performs reviews of providers who received payment for services to participants. Providers must provide documentation to MMAC that services were delivered. Anytime a claim is refunded or recouped due to inappropriate billings, the claim is adjusted in the system. The adjustment is reported on the CMS-64.

The MMAC conducts reviews of provider payments to ensure the provider has evidence/documentation that services were provided. Only authorized services are paid. Payment is made directly to the provider of service.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***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.

The Department of Mental Health will implement nine incentive payments. The performance period will be a state fiscal year starting with state fiscal 2023. The Non-federal funding sources for the value based payment incentives will be made from the temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) under section 9817 of the American Rescue Plan Act of 2021 (ARP) Fund appropriated by the Missouri General Assembly through the Department of Mental Health appropriations. Even though the Department of Mental Health provides the non-federal funding, the source is the General Revenue Fund that would be the same fund if the appropriation was to the Medicaid agency.

The Division of Developmental Disabilities with the assistance of administrative contractors will collect and monitor incentive data. The Division of Developmental Disabilities will make the final determination that a payment is earned. Additional incentive detail is located in the provider's contract and on the Division's webpage Value Based Payments (VBP) | dmh.mo.gov.

1. Establish Incentive Payments for DMH DD Agency Personal Assistant Services (Not Self-Directed) where Personal Assistant Waiver Providers are engaged in Electronic Verification Visit (EVV) with the Missouri EVV Aggregator

Payment earned and paid to DMH DD agency personal assistant service provider to interface with an EVV vendor, complete state system aggregator registration with on-boarding training, and successfully transmit verified personal assistant service EVV records to the state aggregator system.

The EVV incentive payment can be earned once every six months (i.e., once for the July-December time period and once for the January-June time period). To earn the payment, the agency personal assistant provider must

successfully transmit at least 80% of their personal assistant service EVV records for the given six-month period to the state aggregator system. The EVV records must contain all required data points. The incentive payment amount paid to the provider is equivalent to 1% of the total Medicaid paid personal assistant claims payment made to the agency personal assistant provider for the applicable six month period. HCBS waiver providers retain 100% of the value based payment incentive supplemental, including the Federal and State Share.

2. Establish Pay for Reporting Incentive Payments for DD DMH waiver employment service providers who submit data elements that report outcomes and activities in the delivery of Career Planning, Prevocational, Job Development, Supported Employment, and Benefits Planning services.

Payment earned and paid to the DMH DD provider for each quarterly report that employment service providers complete and submit to the state.

A provider can earn the incentive payment for each quarterly episode of pay for reporting (i.e., four times per year), as outlined in the provider contract. The quarterly payment is equivalent to $55 and is only paid for a service-reporting episode where the provider completes 100% of the activities report containing all required data points. HCBS waiver providers retain 100% of the value based payment incentive supplemental, including the Federal and State Share.

3. Establish Incentive Payments for DMH DD HCBS waiver providers who employ new Direct Support Professionals who participate in the US Department of Labor Missouri Talent Pathways Registered Apprenticeship (Missouri Talent Pathways | dmh.mo.gov).

Payment earned and paid to the DMH DD provider for each qualifying direct support professional that a waiver provider recruits to participate in the Talent Pathways apprenticeship program. This incentive payment is applicable when the DMH DD waiver provider organization contracts for one or more of the following waiver services: Personal Assistant, Personal Assistant - Medical Exception, Day Habilitation, Day Habilitation - Behavioral Exception, Day Habilitation - Medical Exception, Community Networking, Individualized Skill Development, Career Planning, Prevocational, Job Development, Supported Employment, In-Home Respite—Day, In-Home Respite—Individual, In-Home Respite—Group, Out-of-Home Respite—Day, Temporary Residential, Residential Group Homes, Individualized Supported Living, and Shared Living.

There are two quality payments available:

- One payment of $1560 is paid to the provider once the direct support professional achieves 50% completion of the Missouri Talent Pathways Certified Direct Support Professional registered apprenticeship program.
- A second payment of $1560 is paid to the provider once a direct support professional achieves full (100%) completion of the Missouri Talent Pathways Certified Direct Support Professional registered apprenticeship program in accordance with required wage increase.

DMH DD HCBS waiver provider eligible employees are either: 1) New direct support professionals who enroll in the Certified Direct Support Professional Apprentice Program within the first 45 days of employment or 2) Previous employees who enroll in the Certified Direct Support Professional Apprentice Program and who have at least 6 months of employment separation from the HCBS waiver provider. HCBS waiver providers retain all 100% of the value based payment incentive supplemental, including the Federal and State Share.

4. Establish incentive payments for DMH DD providers who demonstrate their non-licensed professional staff who deliver Home and Community Based services have completed certain levels of direct support professional training above the required training. This incentive payment is applicable when the DMH DD waiver provider organization contracts for one or more of the following waiver services: Personal Assistant, Personal Assistant - Medical Exception, Day Habilitation, Day Habilitation - Behavioral Exception, Day Habilitation - Medical Exception, Community Networking, Individualized Skill Development, Career Planning, Prevocational, Job Development, Supported Employment, In-Home Respite—Day, In-Home Respite—Individual, In-Home Respite—Group, Out-of-Home Respite—Day, Residential Group Homes, Individualized Supported Living, and Shared Living.

Payment earned and paid to the DMH DD provider based on percentage of staff meeting a given training level.

Three levels of incentive payments are available as follows:

1. Provider can demonstrate that 90% of their DSP workforce that has at least 6 month tenure with the same agency has completed level 1 DSP training;
2. Provider can demonstrate that level 1 DSP benchmark has been met and maintained and 50% of DSP workforce that has at least 6 months tenure with the same agency has completed level 2 DSP training;
3. Provider can demonstrate that level 1 and 2 DSP benchmarks have been met and maintained and 50% of DSP workforce that has at least 1 year tenure with the same agency has completed level 3 DSP training.

A DMH DD provider may earn an incentive payment for each training level twice a year, once every six months (i.e., once for the July-December time period and once for the January-June time period). To earn the payment(s), the provider must provide documentation to the state that shows their DSP workforce has met one of the above training levels for the six-month time period. The incentive payment amount is equivalent to 1% per each training level (maximum of 3%) of the total applicable Medicaid paid claims made to the agency provider for the applicable six month period. Applicable Medicaid paid claims are: Personal Assistant, Personal Assistant - Medical Exception, Day Habilitation, Day Habilitation - Behavioral Exception, Day Habilitation - Medical Exception, Community Networking, Individualized Skill Development, Career Planning, Prevocational, Job Development, Supported Employment, In-Home Respite—Day, In-Home Respite—Individual, In-Home Respite—Group, Out-of-Home Respite—Day, Temporary Residential, Residential Group Homes, Individualized Supported Living, and Shared Living. HCBS waiver providers retain all 100% of the value based payment incentive supplemental, including the Federal and State Share.

5. Establish Incentive Payments for DMH DD HCBS Waiver service providers of residential, in-home, and non-residential services that complete the National Core Indicator (NCI) Staff Stability Survey and subsequent annual NCI Staff Stability Surveys.

Payment earned and paid to the DMH DD provider organization for annual survey completion in the NCI Odessa system.

There is one payment available per year per DMH DD provider organization. The payment is an annual lump sum payment of $2,000. This incentive payment is applicable when the waiver provider organization contracts for one or more of the following waiver services: Personal Assistant, Personal Assistant - Medical Exception, Day Habilitation, Day Habilitation - Behavioral Exception, Day Habilitation - Medical Exception, Community Networking, Individualized Skill Development, Career Planning, Prevocational, Job Development, Supported Employment, In-Home Respite—Day, In-Home Respite—Individual, In-Home Respite—Group, Out-of-Home Respite—Day, Temporary Residential, Residential Group Homes, and Individualized Supported Living, and Shared Living providers. To earn the payment, the provider must submit a completed NCI Staff Stability Survey to the NCI Odessa system by NCI's deadline. HCBS waiver providers retain 100% of the value based payment incentive supplemental, including the Federal and State Share.

6. Establish Incentive Payments for DMH DD Agency Residential Service; Group Home, Individualized Supported Living, and Shared Living where designated provider agency staff serving in the role of the Health Risk Screening Tool (HRST) Rater are engaged in completing the initial HRST for waiver participants.

Payment earned and paid to the DMH DD provider when designated provider agency staff successfully complete the initial HRST for waiver participants in the IntellectAbility electronic system.

There is a one-time payment of $72.20 to the DMH DD provider for each individual initial HRST that a provider completes prior to end of State Fiscal Year 2023. HCBS waiver providers retain 100% of the value based payment incentive supplemental, including the Federal and State Share.

7. Establish Incentive Payments for DMH DD Agency Respite and Agency Individualized Supported Living Services where waiver Agency Respite & Agency ISL providers have assisted waiver participants to implement Remote Supports.

Payment earned and paid to the DMH DD Agency Individualized Supported Living and Agency Respite provider based on cost savings realized through the implementation of Remote Supports in the Assistive Technology service and the correlating decrease in Agency Respite and Agency Individualized Supported Living

services.

The payment to the DMH DD provider is equivalent to 15% of the savings realized due to the reduction of individualized supported living or respite paid supports with the implementation of remote supports. The savings is calculated as follows:

Individualized Supported Living
a. The hours authorized to Individualized Supported Living in the month prior to remote support implementation at the current ISL unit rate reimbursed OR when the two services are implemented simultaneously and no previous month of Individualized Supported Living exists, the savings is based on the individual's share of twenty-four hours a day of Individualized Supported Living at the current unit rate reimbursement supports. LESS
b. The hours authorized to Individualized Supported Living at the current unit rate in the remote support implemented eligible month of the quality incentive payment LESS
c. The monthly authorized amount for remote support components (purchase, lease, monthly service agreement, and remote response staff).

Agency respite
d. The difference of average respite hours per month utilized in the previous individualized support plan year less the respite hours utilized in the remote support implemented eligible month of the quality incentive payment equals the number of hours saved.
e. The number of respite hours saved at the current respite reimbursement rate LESS
f. The number of respite hours saved at the hourly cost of all remote support components (purchase, lease, monthly service agreement, and remote response staff).

The savings is calculated monthly and summed across the previous six (6) calendar month period. Then this is multiplied by 15% to obtain the provider's incentive payment. A provider may earn the quality payment up to twice a year. HCBS waiver providers retain 100% of the value based payment incentive supplemental, including the Federal and State Share.

8. Establish Pay for Reporting incentive payments for DMH DD waiver providers who deliver Individualized Supported Living (ISL) services and submit identified positive behavior support data elements.

Payment earned and paid to the DMH DD provider for active Tiered Agencies that provide Individualized Supported Living and submit 100% of data elements identified in the tiered supports monthly data share (Tiered Supports | dmh.mo.gov).

Twelve payments of $174 paid to ISL agencies are available, one for each month in which 100% of data elements for the previous calendar month are reported. DMH DD HCBS waiver providers retain 100% of the value based payment incentive supplemental, including the Federal and State Share.

9. Establish quality incentive payments for DMH DD Agency Individualized Supported Living providers who successfully implement Tiered Supports

Payment earned and paid to DMH DD ISL agencies who implement Tiered Supports system using criteria defined in the provider contract.

Three levels of payment are available on a quarterly basis:

1. High Implementation Payment: The agency demonstrates evidence of substantial implementation of best practice positive behavior support on quarterly Tier One Systems Assessment. This includes adoption and execution of PBS values, regular data-based problem solving, regular communication channels, competency-based training and ongoing coaching of direct support staff, and data systems

that capture agency processes and immediate outcomes. Payments of $15,000 paid to the provider are available, one for each quarter in which this level of implementation is met for the previous quarter. HCBS providers retain 100% of the value based payment incentive supplemental, including the Federal and State Share.

2. Moderate Implementation Payment: The agency demonstrates evidence of moderate implementation of best practice positive behavior support on quarterly Tier One Systems Assessment. This includes partial adoption and execution of PBS values, regular data-based problem solving, regular communication channels, competency-based training and ongoing coaching of direct support staff, and data systems that capture agency processes and immediate outcomes. Payments of $10,500 paid to the provider are available, one for each quarter in which this level of implementation is met for the previous quarter. HCBS providers retain 100% of the value based payment incentive supplemental, including the Federal and State Share.

3. Low Implementation Payment: The agency demonstrates evidence of minimal implementation of best practice positive behavior support on quarterly Tier One Systems Assessment. This includes planning for adoption and execution of PBS values, regular data-based problem solving, regular communication channels, competency-based training and ongoing coaching of direct support staff, and data systems that capture agency processes and immediate outcomes. Payments of $6,000 paid to the provider are available, one for each quarter in which this level of implementation is met for the previous quarter. HCBS providers retain 100% of the value based payment incentive supplemental, including the Federal and State Share.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

a. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Some county entities are reimbursed as waiver service providers, as well as Division of DD regional offices and habilitation centers. Temporary Residential services may be provided as a direct service by a county entity, or an habilitation center. County Entities and Regional Offices may also provide the following services as a direct service: day habilitation, personal assistant, support broker, community specialist, supported employment, prevocational services, career planning, ABA services, speech therapy, occupational therapy, physical therapy, PAM, environmental accessibility adaptations, specialized medical equipment and supplies, assistive technology, agency with choice FMS, or transportation. The county entity or regional office must have staff qualified to provide the service and must have been chosen by the participant to provide the service.

Both county entities and regional offices are more likely to provide waiver services under the OHCDS option, sub-contracting for waiver services from otherwise qualified providers that have chosen not to enroll as a MO HealthNet (Medicaid) provider.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

b. 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:

- ◉ ***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:

09/24/2021

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

c. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

d. 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:

a) Entities that may be designated as an OHCDS are Division of DD Regional Offices and other MO HealthNet service providers that meet the requirements set forth in 42 CFR 447.10, and desire to serve as an OHCDS. There are no restrictions as to waiver services that may be provided under this option as long as all applicable provider standards are met for that service. They have systems capable of contracting and paying other providers directly. Other waiver providers of MO HealthNet services may also elect to become an OHCDS provider if they are approved by the local Regional Office and have systems capable of contracting with and paying waiver service providers directly and meet the assurances. The ability to contract directly with providers allows individuals and families to select and develop or train individuals they want to deliver services and care, thereby increasing the individual's self-determination. The OHCDS option also enhances the availability and responsiveness of the service delivery system for individuals and their families.

(b) Any qualified provider of a waiver service may enroll directly with MO HealthNet as a Division of DD waiver provider. Providers are not required to provide services through an OHCDS arrangement. The OHCDS option allows individuals and families the ability to select and develop or train individuals they want to deliver services and care, thereby increasing the individual's self-determination. The OHCDS option also enhances the availability and responsiveness of the service delivery system for consumers and their families. Completing the enrollment process through the MO HealthNet program can take time. Contracting with an OHCDS qualified entity may be an expedient way to get services started. The option expands provider choice for consumers and families.

(c) Individuals have free choice of qualified providers and are not required to access services through an OHCDS entity/arrangement. Providers are not required to contract with OHCDS entities, but may do so by choice. Qualified providers may enroll with MMAC to become a MO HealthNet waiver provider.

(d) Provider agencies that have OHCDS designation have a specialized contract with the DMH and with MO HealthNet. The agreement specifies the following:

- *Individual providers and agency providers are not required to contract with an OHCDS under the waiver.*
- *All persons or agencies which do contract with an OHCDS to provide waiver services must meet the same requirements and qualifications as apply to providers enrolled directly with the Medicaid agency.*
- *No OHCDS or contractor will be allowed to limit a recipient's free choice of provider.*
- *Any state entity wishing to be designated an OHCDS must agree to bill the Medicaid program no more than its cost.*
- *All contracts executed by an OHCDS, and all subcontracts executed by its contractors, to provide waiver services, must meet the applicable requirements of 42 CFR 434.6 and 45 CFR Part 74, appendix G.*

(e) MMAC is responsible for enrolling all waiver providers as Missouri Medicaid providers. A standard provider qualification for each waiver provider is that the provider have an active contract to provide waiver services for the Division of DD. This contract is required along with other MO HealthNet provider enrollment forms and any other proof of license or other credential in order for the provider to enroll as a Missouri Medicaid provider of waiver services.

In addition, support coordinators inform individuals of qualified providers and assist individuals in exercising choice. Regional Offices use the OHCDS option to expand choice by contracting or until the provider enrollment process is completed.

(f) Regional Offices bill the same amount to MO HealthNet as the Regional Office paid the contract provider. MMAC Unit has the responsibility for reviewing paid claims. MMAC reviews paid claims by provider type or by specialty type if the provider type is too broad in scope. They select a sample within a set timeframe. Providers must maintain sufficient documentation to prove they provided services for which they were paid by MO HealthNet. In addition, all services are prior authorized to qualified providers, by Regional Offices. Support Coordinators monitor services to determine if the services authorized in the plan are being received and if the services are meeting the individual's needs.

iii. Contracts with MCOs, PIHPs or PAHPs.

◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***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:

a) The non-federal share is appropriated to DMH, Division of DD from General Revenue and Mental Health Local Tax Fund.

b) The State utilizes Intergovernmental Transfers (IGT). Funds from any local government (County Boards) are deposited into the Mental Health Local Tax Fund with Division of DD, and expenditures for the State share for services in their county are made through Division of DD appropriations. MO HealthNet through the use of IGT directly accesses the Division of DD appropriations when making payments to providers. In addition, funds used for the state share for services delivered by private providers are also made through an IGT process from DMH general revenue appropriations.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

○ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☒ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

a) Some Missouri counties have passed laws that give them authority to levy taxes for residents who have DD. Legislation which allows an individual county to create a local DD authority and through a vote of the citizens of the county collect a special tax levied on property up to 40 cents per hundred dollars valuation on property. RSMo 205.968-205.973 is the statutory reference.

b) The source of their revenue is the special tax on property.

c) Funds from any local government (county boards) that are designated for the state share are deposited into the Mental Health Local Tax Fund with Division of DD, and expenditures for the State share for services in their county are made through Division of DD appropriations. MO HealthNet through delegation of authority directly accesses the Division of DD appropriations when making payments to providers.

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  Check each that applies:

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The only service that is provided in a residential setting is Temporary Residential Service. Federal Financial Participation (FFP) is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

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	5531.83	11945.87	17477.70	258573.60	3900.10	262473.70	244996.00
2	5636.93	12208.68	17845.61	264779.37	3985.91	268765.28	250919.67
3	5880.21	12477.27	18357.48	271134.07	4073.60	275207.67	256850.19
4	6420.89	12751.77	19172.66	277641.29	4163.21	281804.50	262631.84
5	6540.83	13032.31	19573.14	284304.68	4254.81	288559.49	268986.35

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	*3220*		*3220*
Year 2	*3220*		*3220*
Year 3	*2875*		*2875*
Year 4	*2500*		*3415*
Year 5	*2500*		*3415*

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 for FY 15 is 273.7; 274 was used in this waiver renewal.

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:*

With the October 2021 waiver amendment for WY 4 & 5, the number of unduplicated participants served was increased to 3415 based on General Assembly utilization appropriation for SFY 2022. It is anticipated that the average units per user and average cost per user will not change with the addition of the slots; therefore no changes were made to these fields.

Factor D projections are based on actual service utilization data from the FY 15 CMS 372 report trended forward to WY 1 based on adjustments for program funding changes passed by the General Assembly. Although FY2015 unduplicated participants was 2,614, the state held the previously projected unduplicated participants (waiver slots) constant at 3,220 to allow for continued growth. With the January 2021 waiver amendment, Waiver Years 3, 4, and 5 number of Unduplicated Participants Served is reduced by from 3,220 to 2,500 based on actual participation and legislative appropriation. This information was applied to the total slots available in the waiver renewal. The unit costs for each waiver service was projected forward using an average trend of 1.9% for years 2, 4, and 5 of the waiver application based on BLS trends. With the January 2021 waiver amendment, Waiver Year 3 projected rate was reduced to 0% since no rate increase was legislatively appropriated for that year. The total projected expenditure was then divided by the unduplicated number of slots available. The projected users for waiver services remain constant for years 2 -5 of the waiver.
Since, Home and Community Based waiver service costs (Factor D) are typically driven by changes in direct care wages (compensation), the BLS Employment Cost Index for Total Compensation was used. We utilized nationwide historical trends specific to the Healthcare and Social Assistance industry. The source link used to obtain the most current data is: https://www.bls.gov/news.release/eci.t05.htm. At the time of waiver submission, the most recent data available was for the 12 months ending September 2017, which reflected a 1.9% trend. This data point is located in Table 5 at the following link:
https://www.bls.gov/news.release/archives/eci_10312017.htm.
Although the annual projections in the current waiver application are approximately 1.9%, the actual COLA increases passed by the General Assembly for FY17, FY18, and FY19 were an annual average of 1.5%. The projected costs for the ABA services consider the 0.68% actual COLA increases. With the January 2021 waiver amendment, the Waiver Year 3 cost per person is an approximate 12% increase in cost per person due to the number unduplicated participant served reduction while the projected average cost per unit and waiver units/user remain constant.

The following additional revisions were made to the ABA projections:

Behavior Identification Assessment was incorrectly noted as a 30 minute unit in Appendix J for all waivers and was actually billable as 1 unit (consistent with the service definition) with a standardized rate. The unit designation error was identified and corrected when working on the ABA procedure code waiver amendment. The service unit designation was converted from 1 unit (typically 2 hours) to 15 minute units which is how the average units per user of 8 was derived for this amendment. An additional error was found in the projections that inadvertently included previous waiver Functional Behavior Assessment service costs in the projected cost per unit. Functional Behavior Assessment service was replaced with the various Applied Behavior Analyst services. The waiver amendment projections was revised to correct the errors.
Behavior Identification Supporting Assessment (Observational Behavior Follow-Up Assessmentt)average cost/unit was incorrectly projected in the current waiver application and should have been a combined weighted average of the rates for the services provided by the tiered provider qualification levels of the (QHCP), (LaBA), and (RBT) in the current waiver application. The projected cost per unit with this waiver amendment was revised to a weighted average of 95% provided by a QHCP, 2.5% LaBA and 2.5% with the RBT.
Adaptive Behavior Treatment by Protocol Administered by Technician projected average cost/unit was revised to a projected average cost/unit by the tiered provider qualification levels of a LaBA and a RBT provider.
Adaptive Behavior Treatment with Protocol Modification projected cost per unit was revised from 100% provided by QHCP to a straight average cost/unit provided by the tiered provider qualification levels of a QHCP and LaBA.
Family Adaptive Behavior Treatment Guidance projected unit cost was averaged by a Qualified Health Professional at $71.02 and Licensed Assistant Behavior Analyst at $40.83 and should have been $92.04 and 53.26, respectively in the current waiver application. This amendment converts from a 60 minute unit to the 15 minute unit and corrects the cost per unit to an average cost/unit provided by the tiered provider qualification levels of a QHCP and LaBA, $23.01 and $13.32 respectively (average of $92.04/4 and $53.26/4).
(Exposure) Adaptive Behavior Treatment with Protocol Modification was incorrectly noted as a 60 minute unit in Appendix J and was actually billable as 30 minute unit (consistent with the service definition). The error was identified and corrected when working on the ABA procedure code waiver amendment. The service unit

designation was converted from 30 minute units to 15 minute units.

With the March 2021 waiver amendment, Person Centered Strategies Consultation service ends on March 1, 2021 and Appendix J was updated accordingly.

With the July 2021 waiver amendment, Individual Goods and Services and Benefits Planning are added as a waiver services effective July 1, 2021. Appendix J was updated accordingly beginning Waiver Year 4. Estimates for users was based on other similar waiver services with consideration for new service ramp up.

Individual Goods and Services users were compared to Specialized Medical Equipment users. In FY19, approximately 19% of waiver individuals utilized SME. Therefore, the state assumed that about half of the 19% (8%) of the Self Directed Users would access Individual Goods and Services.

Benefits Planning users is approximately 50% of the users projected for Career Planning.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is based on actual paid claims data from the FY15 CMS 372 report trended forward 2.2% annually based on BLS Medical CPI. Medical State Plan service projected costs (Factor D' and Factor G') were trended based on the BLS Consumer Price Index for all Urban Consumers (12 months ended November 2017). We used the nationwide historical trend across all categories since it wasn't significantly different than the historical trend on the medical services line. At the time of waiver submission, the most recent data available was for the 12 months ending November 2017. The source link used to obtain the BLS Medical CPI for State Plan services: https://www.bls.gov/opub/ted/2017/cpi-u-up-2-point-2-percent-over-12-months-ended-november-2017.htm (visited January 09, 2018). This cost was divided by the unduplicated number of persons receiving these services to compute an annual average cost.

There were no Medicare Part D figures in this data.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The basis for determining Factor G for institutional costs was based on ICF/ID actual cost data 2017 for the four state habilitation centers. Factor G was trended annually by 2.4% based BLS trends. Direct care wages are one of the main drivers behind Intermediate Care Facility unit costs for Individuals with Developmental Disabilities (ICF/ID) (Factor G). Therefore, Factor G was trended based on the BLS Employment Cost Index for Total Compensation. We utilized nationwide historical growth rates specific to Nursing and Residential Care Facilities. The source link used to obtain the most current data is: https://www.bls.gov/news.release/eci.t05.htm. At the time of waiver submission, the most recent data available was for the 12 months ending September 2017, which reflected a 2.4% trend. This data point is located in Table 5 at the following link: https://www.bls.gov/news.release/archives/eci_10312017.htm.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The basis for determining Factor G' for acute care costs for institutionalized participants was based on actual state plan claims data from 2017 for the four state habilitation centers. Factor G' was trended annually by 2.2% based on BLS Medical CPI. Medical State Plan service projected costs (Factor D' and Factor G') were trended based on the BLS Consumer Price Index for all Urban Consumers (12 months ended November 2017). We used the nationwide historical trend across all categories since it wasn't significantly different than the historical trend on the medical services line. At the time of waiver submission, the most recent data available was for the 12 months ending November 2017. The source link used to obtain the BLS Medical CPI for State Plan services: https://www.bls.gov/opub/ted/2017/cpi-u-up-2-point-2-percent-over-12-months-ended-november-2017.htm (visited January 09, 2018).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these*

components.

Waiver Services	
Day Habilitation	
Personal Assistant Services	
Prevocational Services	
Supported Employment	
Dental	
Support Broker	
Applied Behavior Analysis (ABA)	
Assistive Technology	
Benefits Planning	
Career Planning	
Community Networking	
Community Specialist	
Community Transition	
Environmental Accessibility Adaptations-Home/Vehicle Modification	
Family Peer Support	
Individual Directed Goods and Services	
Individualized Skill Development	
Job Development	
Occupational Therapy	
Person Centered Strategies Consultation	
Physical Therapy	
Professional Assessment and Monitoring	
Specialized Medical Equipment and Supplies (Adaptive Equipment)	
Speech Therapy	
Temporary Residential Service	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**2157323.56**
Day Habilitation Medical Exception	15 Minutes	14	550.00	8.10	**62370.00**	
				GRAND TOTAL:		**17812492.05**
				Total Estimated Unduplicated Participants:		**3220**
				Factor D (Divide total by number of participants):		**5531.83**
				Average Length of Stay on the Waiver:		274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Behavioral Exception	15 Minutes	14	550.00	7.52	57904.00	
Day Habilitation Group	15 Minutes	282	1323.00	5.46	2037049.56	
Personal Assistant Services Total:						5652542.75
Personal Assistant - Medical - Agency	15 minutes	167	761.00	5.46	693895.02	
Personal Assistant - Medical - Self-Directed	15 minutes	14	1410.00	4.61	91001.40	
Personal Assistant - Agency	15 minutes	507	892.00	4.55	2057710.20	
Personal Assistant - Group	15 minutes	57	1515.00	3.61	311741.55	
Personal Assistant - Individual-Self Directed	15 minutes	362	2219.00	3.11	2498194.58	
Prevocational Services Total:						570342.00
Prevocational, Individual	15 minutes	42	288.00	9.50	114912.00	
Prevocational, Group	15 minutes	76	1275.00	4.70	455430.00	
Supported Employment Total:						237209.16
Individual Supported Employment	15 minutes	42	376.00	11.48	181292.16	
Group Supported Employment	15 minutes	18	654.00	4.75	55917.00	
Dental Total:						178148.16
Dental	1 visit	79	3.00	751.68	178148.16	
Support Broker Total:						7112.60
Support Broker, Agency	15 minutes	20	53.00	6.71	7112.60	
Applied Behavior Analysis (ABA) Total:						321868.97
Adaptive Behavior Tx by Protocol Administered by Technician	15 minutes	30	50.00	10.45	15675.00	
Behavior Identification Supporting Assessment (Observational Behavioral Follow-Up Assessment)	15 minutes	103	6.00	22.51	13911.18	
Behavior					4740.06	

GRAND TOTAL:	17812492.05
Total Estimated Unduplicated Participants:	3220
Factor D (Divide total by number of participants):	5531.83
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Identification Supporting Assessment (Exposure Behavioral Follow-Up Assessment)	15 minutes	103	2.00	23.01		
(Exposure) Adaptive Behavior Tx w/Protocol Modification	15 minutes	41	90.15	23.01	85048.41	
Behavior Identification Assessment	15 minutes	103	8.00	23.01	18960.24	
Adaptive Behavior Tx w/Protocol Modification	15 minutes	69	90.15	18.17	113023.76	
Group Adaptive Behavior Treatment with Protocol Modification (Behavior Treatment Social Skills Group)	15 minutes	80	108.00	1.65	14256.00	
Family Adaptive Behavior Treatment Guidance	15 minutes	43	72.00	18.17	56254.32	
Assistive Technology Total:						25746.60
Assistive Technology	1 job	22	3.00	390.10	25746.60	
Benefits Planning Total:						0.00
Benefits Planning	15 minutes	0	0.00	11.14	0.00	
Career Planning Total:						44089.50
Career Planning, Individual	15 minutes	13	357.00	9.50	44089.50	
Community Networking Total:						5190338.56
Community Networking, Individual	15 minutes	823	656.00	8.63	4659233.44	
Community Networking, Group	15 minutes	252	386.00	5.46	531105.12	
Community Specialist Total:						184519.78
Community Specialist-Self Directed	15 minutes	6	664.00	7.67	30557.28	
Community Specialist-Agency	15 minutes	113	125.00	10.90	153962.50	
Community Transition Total:						15000.00
Community Transition	1 job	5	1.00	3000.00	15000.00	
Environmental Accessibility						348057.90

GRAND TOTAL:	17812492.05
Total Estimated Unduplicated Participants:	3220
Factor D (Divide total by number of participants):	5531.83
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptations-Home/Vehicle Modification Total:						
Environmental Accessibility Adaptations-Home/Vehicle Modification	1 job	45	2.00	3867.31	348057.90	
Family Peer Support Total:						3096.60
Family Peer Support, Individual	15 minutes	5	52.00	8.51	2212.60	
Family Peer Support, Group	15 minutes	5	52.00	3.40	884.00	
Individual Directed Goods and Services Total:						0.00
Individual Directed Goods and Services	1 job	0	0.00	3000.00	0.00	
Individualized Skill Development Total:						366489.92
Individualized Skill Development, Individual	15 minutes	228	265.00	5.94	358894.80	
Individualized Skill Development, Group	15 minutes	13	109.00	5.36	7595.12	
Job Development Total:						64125.00
Job Development, Individual	15 minutes	27	250.00	9.50	64125.00	
Occupational Therapy Total:						21106.80
Occupational Therapy	15 minutes	20	66.00	15.99	21106.80	
Person Centered Strategies Consultation Total:						328304.34
Person Centered Strategies Consultation	15 minutes	153	131.00	16.38	328304.34	
Physical Therapy Total:						18011.16
Physical Therapy	15 minutes	9	109.00	18.36	18011.16	
Professional Assessment and Monitoring Total:						11101.89
Registered Nurse	15 minutes	3	269.00	12.27	9901.89	
Licensed Practical Nurse	15 minutes	1	96.00	6.12	587.52	
Dietitian	15 minutes	1	96.00	6.38	612.48	

GRAND TOTAL:	17812492.05
Total Estimated Unduplicated Participants:	3220
Factor D (Divide total by number of participants):	5531.83
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies (Adaptive Equipment) Total:						**392323.60**
Specialized Medical Equipment and Supplies (Adaptive Equipment)	1 item	248	5.00	316.39	**392323.60**	
Speech Therapy Total:						**26203.20**
Speech Therapy	15 minutes	15	103.00	16.96	**26203.20**	
Temporary Residential Service Total:						**90389.52**
Temporary Residential Service	1 day	37	18.00	135.72	**90389.52**	
Transportation Total:						**1559040.48**
Transportation	1 month	626	9.00	276.72	**1559040.48**	
				GRAND TOTAL:		**17812492.05**
				Total Estimated Unduplicated Participants:		**3220**
				Factor D (Divide total by number of participants):		**5531.83**
				Average Length of Stay on the Waiver:		274

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**2196865.16**
Day Habilitation Medical Exception	15 Minutes	14	550.00	8.25	**63525.00**	
Day Habilitation Behavioral Exception	15 Minutes	14	550.00	7.66	**58982.00**	
Day Habilitation Group	15 Minutes	282	1323.00	5.56	**2074358.16**	
Personal Assistant Services Total:						**5758719.97**
Personal Assistant - Medical - Agency	15 minutes	167	761.00	5.57	**707874.59**	
				GRAND TOTAL:		**18150898.86**
				Total Estimated Unduplicated Participants:		**3220**
				Factor D (Divide total by number of participants):		**5636.93**
				Average Length of Stay on the Waiver:		274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistant - Medical - Self-Directed	15 minutes	14	1410.00	4.70	92778.00	
Personal Assistant - Agency	15 minutes	507	892.00	4.63	2093889.72	
Personal Assistant - Group	15 minutes	57	1515.00	3.68	317786.40	
Personal Assistant - Individual-Self Directed	15 minutes	362	2219.00	3.17	2546391.26	
Prevocational Services Total:						581240.28
Prevocational, Individual	15 minutes	42	288.00	9.68	117089.28	
Prevocational, Group	15 minutes	76	1275.00	4.79	464151.00	
Supported Employment Total:						241742.88
Individual Supported Employment	15 minutes	42	376.00	11.70	184766.40	
Group Supported Employment	15 minutes	18	654.00	4.84	56976.48	
Dental Total:						181532.52
Dental	1 visit	79	3.00	765.96	181532.52	
Support Broker Total:						7250.40
Support Broker, Agency	15 minutes	20	53.00	6.84	7250.40	
Applied Behavior Analysis (ABA) Total:						327925.98
Adaptive Behavior Tx by Protocol Administered by Technician	15 minutes	30	50.00	10.64	15960.00	
Behavior Identification Supporting Assessment (Observational Behavioral Follow-Up Assessment)	15 minutes	103	6.00	22.94	14176.92	
Behavior Identification Supporting Assessment (Exposure Behavioral Follow-Up Assessment)	15 minutes	103	2.00	23.45	4830.70	
(Exposure) Adaptive Behavior Tx w/Protocol Modification	15 minutes	41	90.15	23.45	86674.72	
Behavior Identification	15 minutes				19322.80	

GRAND TOTAL:	18150898.86
Total Estimated Unduplicated Participants:	3220
Factor D (Divide total by number of participants):	5636.93
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment		103	8.00	23.45		
Adaptive Behavior Tx w/Protocol Modification	15 minutes	69	90.15	18.51	115138.68	
Group Adaptive Behavior Treatment with Protocol Modification (Behavior Treatment Social Skills Group)	15 minutes	80	108.00	1.68	14515.20	
Family Adaptive Behavior Treatment Guidance	15 minutes	43	72.00	18.51	57306.96	
Assistive Technology Total:						26236.32
Assistive Technology	1 job	22	3.00	397.52	26236.32	
Benefits Planning Total:						0.00
Benefits Planning	15 minutes	0	0.00	11.14	0.00	
Career Planning Total:						44924.88
Career Planning, Individual	15 minutes	13	357.00	9.68	44924.88	
Community Networking Total:						5291846.72
Community Networking, Individual	15 minutes	823	656.00	8.80	4751014.40	
Community Networking, Group	15 minutes	252	386.00	5.56	540832.32	
Community Specialist Total:						187942.38
Community Specialist-Self Directed	15 minutes	6	664.00	7.82	31154.88	
Community Specialist-Agency	15 minutes	113	125.00	11.10	156787.50	
Community Transition Total:						15285.00
Community Transition	15 minutes	5	1.00	3057.00	15285.00	
Environmental Accessibility Adaptations-Home/Vehicle Modification Total:						354671.10
Environmental Accessibility Adaptations-Home/Vehicle Modification	1 job	45	2.00	3940.79	354671.10	
Family Peer Support Total:						3153.80

GRAND TOTAL:	18150898.86
Total Estimated Unduplicated Participants:	3220
Factor D (Divide total by number of participants):	5636.93
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Peer Support, Individual	15 minutes	5	52.00	8.67	2254.20	
Family Peer Support, Group	15 minutes	5	52.00	3.46	899.60	
Individual Directed Goods and Services Total:						0.00
Individual Directed Goods and Services	1 job	0	0.00	3000.00	0.00	
Individualized Skill Development Total:						373277.82
Individualized Skill Development, Individual	15 minutes	228	265.00	6.05	365541.00	
Individualized Skill Development, Group	15 minutes	13	109.00	5.46	7736.82	
Job Development Total:						65340.00
Job Development, Individual	15 minutes	27	250.00	9.68	65340.00	
Occupational Therapy Total:						21502.80
Occupational Therapy	15 minutes	20	66.00	16.29	21502.80	
Person Centered Strategies Consultation Total:						334517.67
Person Centered Strategies Consultation	15 minutes	153	131.00	16.69	334517.67	
Physical Therapy Total:						18354.51
Physical Therapy	15 minutes	9	109.00	18.71	18354.51	
Professional Assessment and Monitoring Total:						11318.61
Registered Nurse	15 minutes	3	269.00	12.51	10095.57	
Licensed Practical Nurse	15 minutes	1	96.00	6.24	599.04	
Dietitian	15 minutes	1	96.00	6.50	624.00	
Specialized Medical Equipment and Supplies (Adaptive Equipment) Total:						399776.00
Specialized Medical Equipment and Supplies (Adaptive Equipment)	1 item	248	5.00	322.40	399776.00	
Speech Therapy Total:						26697.60
Speech Therapy					26697.60	

GRAND TOTAL:	18150898.86
Total Estimated Unduplicated Participants:	3220
Factor D (Divide total by number of participants):	5636.93
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minutes	15	103.00	17.28		
Temporary Residential Service Total:						**92101.14**
Temporary Residential Service	1 day	37	18.00	138.29	**92101.14**	
Transportation Total:						**1588675.32**
Transportation	1 month	626	9.00	281.98	**1588675.32**	
				GRAND TOTAL:		**18150898.86**
				Total Estimated Unduplicated Participants:		**3220**
				Factor D (Divide total by number of participants):		**5636.93**
				Average Length of Stay on the Waiver:		274

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**2055708.82**
Day Habilitation Medical Exception	15 Minutes	13	550.00	8.25	**58987.50**	
Day Habilitation Behavioral Exception	15 Minutes	13	550.00	7.66	**54769.00**	
Day Habilitation Group	15 Minutes	264	1323.00	5.56	**1941952.32**	
Personal Assistant Services Total:						**5393458.46**
Personal Assistant - Medical - Agency	15 minutes	157	761.00	5.57	**665486.89**	
Personal Assistant - Medical - Self-Directed	15 minutes	13	1410.00	4.70	**86151.00**	
Personal Assistant - Agency	15 minutes	475	892.00	4.63	**1961731.00**	
Personal Assistant - Group	15 minutes	53	1515.00	3.68	**295485.60**	
Personal Assistant - Individual-Self	15 minutes	339	2219.00	3.17	**2384603.97**	
				GRAND TOTAL:		**16905605.14**
				Total Estimated Unduplicated Participants:		**2875**
				Factor D (Divide total by number of participants):		**5880.21**
				Average Length of Stay on the Waiver:		274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Directed						
Prevocational Services Total:						**542340.51**
Prevocational, Individual	15 minutes	39	288.00	9.68	**108725.76**	
Prevocational, Group	15 minutes	71	1275.00	4.79	**433614.75**	
Supported Employment Total:						**225379.92**
Individual Supported Employment	15 minutes	39	376.00	11.70	**171568.80**	
Group Supported Employment	15 minutes	17	654.00	4.84	**53811.12**	
Dental Total:						**170043.12**
Dental	1 visit	74	3.00	765.96	**170043.12**	
Support Broker Total:						**6887.88**
Support Broker, Agency	15 minutes	19	53.00	6.84	**6887.88**	
Applied Behavior Analysis (ABA) Total:						**308039.74**
Adaptive Behavior Tx by Protocol Administered by Technician	15 minutes	28	50.00	10.64	**14896.00**	
Behavior Identification Supporting Assessment (Observational Behavioral Follow-Up Assessment)	15 minutes	97	6.00	22.94	**13351.08**	
Behavior Identification Supporting Assessment (Exposure Behavioral Follow-Up Assessment)	15 minutes	97	2.00	23.45	**4549.30**	
(Exposure) Adaptive Behavior Tx w/Protocol Modification	15 minutes	38	90.15	23.45	**80332.66**	
Behavior Identification Assessment	15 minutes	97	8.00	23.45	**18197.20**	
Adaptive Behavior Tx w/Protocol Modification	15 minutes	65	90.15	18.51	**108463.97**	
Group Adaptive Behavior Treatment with Protocol Modification (Behavior Treatment Social Skills Group)	15 minutes	75	108.00	1.68	**13608.00**	

GRAND TOTAL:	**16905605.14**
Total Estimated Unduplicated Participants:	**2875**
Factor D (Divide total by number of participants):	**5880.21**
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Adaptive Behavior Treatment Guidance	15 minutes	41	72.00	18.51	54641.52	
Assistive Technology Total:						25043.76
Assistive Technology	1 job	21	3.00	397.52	25043.76	
Benefits Planning Total:						0.00
Benefits Planning	15 minutes	0	0.00	11.14	0.00	
Career Planning Total:						41469.12
Career Planning, Individual	15 minutes	12	357.00	9.68	41469.12	
Community Networking Total:						4957322.56
Community Networking, Individual	15 minutes	771	656.00	8.80	4450828.80	
Community Networking, Group	15 minutes	236	386.00	5.56	506493.76	
Community Specialist Total:						178229.88
Community Specialist-Self Directed	15 minutes	6	664.00	7.82	31154.88	
Community Specialist-Agency	15 minutes	106	125.00	11.10	147075.00	
Community Transition Total:						15285.00
Community Transition	1 job	5	1.00	3057.00	15285.00	
Environmental Accessibility Adaptations-Home/Vehicle Modification Total:						331026.36
Environmental Accessibility Adaptations-Home/Vehicle Modification	1 job	42	2.00	3940.79	331026.36	
Family Peer Support Total:						3153.80
Family Peer Support, Individual	15 minutes	5	52.00	8.67	2254.20	
Family Peer Support, Group	15 minutes	5	52.00	3.46	899.60	
Individual Directed Goods and Services Total:						0.00
Individual Directed Goods and Services	1 job				0.00	

GRAND TOTAL:	16905605.14
Total Estimated Unduplicated Participants:	2875
Factor D (Divide total by number of participants):	5880.21
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		0	0.00	3000.00		
Individualized Skill Development Total:						**350237.18**
Individualized Skill Development, Individual	15 minutes	214	265.00	6.05	**343095.50**	
Individualized Skill Development, Group	15 minutes	12	109.00	5.46	**7141.68**	
Job Development Total:						**60500.00**
Job Development, Individual	15 minutes	25	250.00	9.68	**60500.00**	
Occupational Therapy Total:						**20427.66**
Occupational Therapy	15 minutes	19	66.00	16.29	**20427.66**	
Person Centered Strategies Consultation Total:						**217692.84**
Person Centered Strategies Consultation	15 minutes	133	98.07	16.69	**217692.84**	
Physical Therapy Total:						**16315.12**
Physical Therapy	15 minutes	8	109.00	18.71	**16315.12**	
Professional Assessment and Monitoring Total:						**11318.61**
Registered Nurse	15 minutes	3	269.00	12.51	**10095.57**	
Licensed Practical Nurse	15 minutes	1	96.00	6.24	**599.04**	
Dietitian	15 minutes	1	96.00	6.50	**624.00**	
Specialized Medical Equipment and Supplies (Adaptive Equipment) Total:						**373984.00**
Specialized Medical Equipment and Supplies (Adaptive Equipment)	1 job	232	5.00	322.40	**373984.00**	
Speech Therapy Total:						**24917.76**
Speech Therapy	15 minutes	14	103.00	17.28	**24917.76**	
Temporary Residential Service Total:						**87122.70**
Temporary Residential Service	1 Day	35	18.00	138.29	**87122.70**	
Transportation Total:						**1489700.34**

GRAND TOTAL:	**16905605.14**
Total Estimated Unduplicated Participants:	**2875**
Factor D (Divide total by number of participants):	**5880.21**
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation	1 month	587	9.00	281.98	1489700.34	
				GRAND TOTAL:		16905605.14
				Total Estimated Unduplicated Participants:		2875
				Factor D (Divide total by number of participants):		5880.21
				Average Length of Stay on the Waiver:		274

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						2459169.60
Day Habilitation Medical Exception	15 Minutes	15	550.00	8.41	69382.50	
Day Habilitation Behavioral Exception	15 Minutes	15	550.00	7.80	64350.00	
Day Habilitation Group	15 Minutes	310	1323.00	5.67	2325437.10	
Personal Assistant Services Total:						6439398.03
Personal Assistant - Medical - Agency	15 minutes	183	761.00	5.67	789621.21	
Personal Assistant - Medical - Self-Directed	15 minutes	15	1410.00	4.79	101308.50	
Personal Assistant - Agency	15 minutes	557	892.00	4.72	2345103.68	
Personal Assistant - Group	15 minutes	63	1515.00	3.75	357918.75	
Personal Assistant - Individual-Self Directed	15 minutes	397	2219.00	3.23	3845445.89	
Prevocational Services Total:						647051.28
Prevocational, Individual	15 minutes	46	288.00	9.86	130625.28	
Prevocational, Group	15 minutes	83	1275.00	4.88	516426.00	
				GRAND TOTAL:		19923085.57
				Total Estimated Unduplicated Participants:		3415
				Factor D (Divide total by number of participants):		5833.99
				Average Length of Stay on the Waiver:		274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:						**217523.20**
Individual Supported Employment	15 minutes	46	376.00	11.92	**206168.32**	
Group Supported Employment	15 minutes	20	654.00	4.94	**64615.20**	
Dental Total:						**203715.72**
Dental	1 visit	87	3.00	780.52	**203715.72**	
Support Broker Total:						**8127.02**
Support Broker, Agency	15 minutes	22	53.00	6.97	**8127.02**	
Applied Behavior Analysis (ABA) Total:						**367931.96**
Adaptive Behavior Tx by Protocol Administered by Technician	15 minutes	33	50.00	10.85	**17902.50**	
Behavior Identification Supporting Assessment (Observational Behavioral Follow-Up Assessment)	15 minutes	113	6.00	23.37	**15844.86**	
Behavior Identification Supporting Assessment (Exposure Behavioral Follow-Up Assessment)	15 minutes	113	2.00	23.89	**5399.14**	
(Exposure) Adaptive Behavior Tx w/Protocol Modification	15 minutes	45	90.00	23.89	**96754.50**	
Behavior Identification Assessment	15 minutes	113	8.00	23.89	**21596.56**	
Adaptive Behavior Tx w/Protocol Modification	15 minutes	76	90.00	18.86	**129002.40**	
Group Adaptive Behavior Treatment with Protocol Modification (Behavior Treatment Social Skills Group)	15 minutes	88	108.00	1.71	**16251.84**	
Family Adaptive Behavior Treatment Guidance	15 minutes	48	72.00	18.86	**65180.16**	
Assistive Technology Total:						**29165.04**
Assistive Technology	1 job	24	3.00	405.07	**29165.04**	
Benefits Planning Total:						**4010.40**

GRAND TOTAL:	**19923085.57**
Total Estimated Unduplicated Participants:	**3415**
Factor D (Divide total by number of participants):	**5833.99**
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Benefits Planning	15 minutes	6	60.00	11.14	4010.40	
Career Planning Total:						49280.28
Career Planning, Individual	15 minutes	14	357.00	9.86	49280.28	
Community Networking Total:						919742.78
Community Networking, Individual	15 minutes	904	656.00	8.96	5313495.04	
Community Networking, Group	15 minutes	277	386.00	5.67	606247.74	
Community Specialist Total:						212349.56
Community Specialist-Self Directed	15 minutes	7	664.00	7.97	37044.56	
Community Specialist-Agency	15 minutes	124	125.00	11.31	175305.00	
Community Transition Total:						15575.40
Community Transition	1 job	5	1.00	3115.08	15575.40	
Environmental Accessibility Adaptations-Home/Vehicle Modification Total:						393535.66
Environmental Accessibility Adaptations-Home/Vehicle Modification	1 job	49	2.00	4015.67	393535.66	
Family Peer Support Total:						3216.20
Family Peer Support, Individual	15 minutes	5	52.00	8.84	2298.40	
Family Peer Support, Group	15 minutes	5	52.00	3.53	917.80	
Individual Directed Goods and Services Total:						270000.00
Individual Directed Goods and Services	1 job	90	1.00	3000.00	270000.00	
Individualized Skill Development Total:						417247.06
Individualized Skill Development, Individual	15 minutes	250	265.00	6.17	408762.50	
Individualized Skill Development, Group	15 minutes	14	109.00	5.56	8484.56	
Job Development Total:						73950.00

GRAND TOTAL:	19923085.57
Total Estimated Unduplicated Participants:	3415
Factor D (Divide total by number of participants):	5833.99
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Job Development, Individual	15 minutes	30	250.00	9.86	73950.00	
Occupational Therapy Total:						24103.20
Occupational Therapy	15 minutes	22	66.00	16.60	24103.20	
Person Centered Strategies Consultation Total:						0.00
Person Centered Strategies Consultation	15 minutes	0	0.00	17.01	0.00	
Physical Therapy Total:						20786.30
Physical Therapy	15 minutes	10	109.00	19.07	20786.30	
Professional Assessment and Monitoring Total:						11526.30
Registered Nurse	15 minutes	3	269.00	12.74	10281.18	
Licensed Practical Nurse	15 minutes	1	96.00	6.35	609.60	
Dietitian	15 minutes	1	96.00	6.62	635.52	
Specialized Medical Equipment and Supplies (Adaptive Equipment) Total:						446787.20
Specialized Medical Equipment and Supplies (Adaptive Equipment)	1 item	272	5.00	328.52	446787.20	
Speech Therapy Total:						29021.28
Speech Therapy	15 minutes	16	103.00	17.61	29021.28	
Temporary Residential Service Total:						103998.96
Temporary Residential Service	1 day	32	18.00	140.92	103998.96	
Transportation Total:						1776623.22
Transportation	1 month	687	9.00	287.34	1776623.22	
				GRAND TOTAL:		19923085.57
				Total Estimated Unduplicated Participants:		3415
				Factor D (Divide total by number of participants):		5833.99
				Average Length of Stay on the Waiver:		274

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to*

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**2506841.40**
Day Habilitation Medical Exception	15 Minutes	15	550.00	8.57	**70702.50**	
Day Habilitation Behavioral Exception	15 Minutes	15	550.00	7.95	**65587.50**	
Day Habilitation Group	15 Minutes	310	1323.00	5.78	**2370551.40**	
Personal Assistant Services Total:						**6560874.15**
Personal Assistant - Medical - Agency	15 minutes	183	761.00	5.78	**804940.14**	
Personal Assistant - Medical - Self-Directed	15 minutes	15	1410.00	4.88	**103212.00**	
Personal Assistant - Agency	15 minutes	557	892.00	4.81	**2389819.64**	
Personal Assistant - Group	15 minutes	63	1515.00	3.82	**364599.90**	
Personal Assistant - Individual-Self Directed	15 minutes	397	2219.00	3.29	**2898302.47**	
Prevocational Services Total:						**660150.90**
Prevocational, Individual	15 minutes	46	288.00	10.05	**133142.40**	
Prevocational, Group	15 minutes	83	1275.00	4.98	**527008.50**	
Supported Employment Total:						**275765.84**
Individual Supported Employment	15 minutes	43	376.00	12.14	**209973.44**	
Group Supported Employment	15 minutes	20	654.00	5.03	**65792.40**	
Dental Total:						**207586.35**
Dental	1 visit	87	3.00	795.35	**207586.35**	
Support Broker Total:						**8278.60**
Support Broker, Agency	15 minutes	22	53.00	7.10	**8278.60**	
Applied Behavior Analysis (ABA) Total:						**374941.54**
Adaptive Behavior Tx by Protocol	15 minutes				**18232.50**	

GRAND TOTAL:	**20301628.93**
Total Estimated Unduplicated Participants:	**3415**
Factor D (Divide total by number of participants):	**5944.84**
Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Administered by Technician		33	50.00	11.05		
Behavior Identification Supporting Assessment (Observational Behavioral Follow-Up Assessment)	15 minutes	113	6.00	23.82	16149.96	
Behavior Identification Supporting Assessment (Exposure Behavioral Follow-Up Assessment)	15 minutes	113	2.00	24.35	5503.10	
(Exposure) Adaptive Behavior Tx w/Protocol Modification	15 minutes	45	90.00	24.35	98617.50	
Behavior Identification Assessment	15 minutes	113	8.00	24.35	22012.40	
Adaptive Behavior Tx w/Protocol Modification	15 minutes	76	90.00	19.22	131464.80	
Group Adaptive Behavior Treatment with Protocol Modification (Behavior Treatment Social Skills Group)	15 minutes	88	108.00	1.74	16536.96	
Family Adaptive Behavior Treatment Guidance	15 minutes	48	72.00	19.22	66424.32	
Assistive Technology Total:						29719.44
Assistive Technology	1 job	24	3.00	412.77	29719.44	
Benefits Planning Total:						4086.00
Benefits Planning	15 minutes	6	60.00	11.35	4086.00	
Career Planning Total:						50229.90
Career Planning, Individual	15 minutes	14	357.00	10.05	50229.90	
Community Networking Total:						6031249.06
Community Networking, Individual	15 minutes	904	656.00	9.13	5414309.12	
Community Networking, Group	15 minutes	277	386.00	5.77	616939.94	
Community Specialist Total:						216456.76
Community Specialist-Self Directed	15 minutes	7	664.00	8.12	37741.76	

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Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Specialist-Agency	15 minutes	124	125.00	11.53	178715.00	
Community Transition Total:						15871.35
Community Transition	1 job	5	1.00	3174.27	15871.35	
Environmental Accessibility Adaptations-Home/Vehicle Modification Total:						401012.08
Environmental Accessibility Adaptations-Home/Vehicle Modification	1 job	49	2.00	4091.96	401012.08	
Family Peer Support Total:						3276.00
Family Peer Support, Individual	15 minutes	5	52.00	9.00	2340.00	
Family Peer Support, Group	15 minutes	5	52.00	3.60	936.00	
Individual Directed Goods and Services Total:						270000.00
Individual Directed Goods and Services	1 job	90	1.00	3000.00	270000.00	
Individualized Skill Development Total:						425364.92
Individualized Skill Development, Individual	15 minutes	250	265.00	6.29	416712.50	
Individualized Skill Development, Group	15 minutes	14	109.00	5.67	8652.42	
Job Development Total:						75375.00
Job Development, Individual	15 minutes	30	250.00	10.05	75375.00	
Occupational Therapy Total:						24567.81
Occupational Therapy	15 minutes	22	66.00	16.92	24567.84	
Person Centered Strategies Consultation Total:						0.00
Person Centered Strategies Consultation	15 minutes	0	0.00	17.33	0.00	
Physical Therapy Total:						21178.70
Physical Therapy	15 minutes	10	109.00	19.43	21178.70	
Professional Assessment						11753.01

GRAND TOTAL:	20301628.93
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Average Length of Stay on the Waiver:	274

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and Monitoring Total:						
Registered Nurse	15 minutes	3	269.00	12.99	**10482.93**	
Licensed Practical Nurse	15 minutes	1	96.00	6.48	**622.08**	
Dietitian	15 minutes	1	96.00	6.75	**648.00**	
Specialized Medical Equipment and Supplies (Adaptive Equipment) Total:						**455273.60**
Specialized Medical Equipment and Supplies (Adaptive Equipment)	1 item	272	5.00	334.76	**455273.60**	
Speech Therapy Total:						**29565.12**
Speech Therapy	15 minutes	16	103.00	17.94	**29565.12**	
Temporary Residential Service Total:						**105976.80**
Temporary Residential Service	1 day	41	18.00	143.60	**105976.80**	
Transportation Total:						**1810320.57**
Transportation	1 month	687	9.00	292.79	**1810320.57**	

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Average Length of Stay on the Waiver:	274