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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

Request for 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:
Independent Living Waiver

C. Waiver Number:MO.0346
Original Base Waiver Number: MO.0346.90.01

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/26
Approved Effective Date of Waiver being Amended: 07/01/24

2. Purpose(s) of Amendment

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

To ensure the fiscal sustainability and operational effectiveness of the personal care services, the provision of personal care services is limited to a maximum of 49 hours per week per participant.

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**	

Component of the Approved Waiver	Subsection(s)
☐ Appendix B - Participant Access and Eligibility	
☒ Appendix C - Participant Services	C-1 personal care
☐ Appendix D - Participant Centered Service Planning and Delivery	
☐ Appendix E - Participant Direction of Services	
☐ Appendix F - Participant Rights	
☐ Appendix G - Participant Safeguards	
☐ Appendix H	
☐ Appendix I - Financial Accountability	
☐ Appendix J - Cost-Neutrality Demonstration	

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☒ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

To ensure the long-term sustainability and operational effectiveness of our program, the provision of personal care services is limited to a maximum of 49 hours per week per participant. This limit is necessary to ensure equitable resource allocation. By implementing this cap, we can continue to provide high-quality support to all participants while maintaining the program's financial stability. Implementing a cap of 49 hours per week for personal care services is a proactive measure to control expenditures, maintain compliance with cost-neutrality standards, and ensure that resources remain available to all participants. This approach supports the program’s sustainability while continuing to provide essential services within established financial limits.

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 section 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*):

Independent Living Waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MO.0346
Draft ID: MO.004.05.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/24
Approved Effective Date of Waiver being Amended: 07/01/24

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: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

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

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

The state does not limit 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 section 1915(a)(1)(a) of the Act and described in Appendix I**

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

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

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

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

☐ **section 1915(b)(2) (central broker)**

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

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

☐ **A program operated under section 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 section 1915(i) of the Act.**

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

☐ **A program authorized under section 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.

Purpose: The Independent Living Waiver (ILW) was developed to provide community-based alternatives to individuals with disabilities 18 years of age and above who otherwise would be institutionalized in a nursing facility as long as they maintain the ability and still desire to self-direct their personal care attendant services.

Goal: Establish and maintain a community-based system of care of individuals 18 years of age and over who have disabilities that live and wish to continue living independently in their homes and/or communities as long as they maintain the ability and still desire to self-direct their personal care attendant services.

Objectives: 1) provide individuals with disabilities the choice between nursing facility institutional care and services that allow them to remain in their home and community in a cost-effective manner, and 2) maintain and improve a community-based system of care that diverts individuals from institutional and residential care.

Organizational Structure: The Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS) administers and operates the waiver through a formal Memorandum of Understanding (MOU) with the State Medicaid Agency, the Department of Social Services (DSS), MO HealthNet Division (MHD) that outlines specific duties related to the administration, operation, and oversight functions of the waiver. DHSS/DSDS provides the direct administrative functions required for the operation of the waiver. In accordance with 42 CFR §431.10, MHD exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver through review and oversight. More specific roles and responsibilities of each agency are specified throughout the waiver application and in the MOU which is available to the Centers for Medicare & Medicaid Services (CMS) upon request through the State Medicaid Agency.

Service Delivery Methods: DSDS staff prior authorizes waiver services. Services are delivered through providers who have a participation agreement (contract) with the DSS, Missouri Medicaid Audit and Compliance Unit (MMAC) as an ILW provider. Waiver services are prior authorized and claims for reimbursement are filed directly with the Medicaid Management Information System (MMIS) fiscal agent for processing and payment. MHD reimburses enrolled waiver providers directly.

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 section 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 section 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 section 1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

3. Assurance that all facilities subject to section 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 section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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:

For this waiver amendment, the Department of Social Services (DSS), MO HealthNet Division (MHD), and the Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS), invited the public to comment on the Independent Living Waiver (ILW) amendment application.

The public notice, along with a complete copy of the waiver amendment application, was published on the DSS website on August 22, 2024, located at the following link https://mydss.mo.gov/mhd/alerts. The public notice was also published in the five (5) newspapers within Missouri for cities with the greatest populations on August 23, 2024.

Complete copies of the amendment application were also available by request from the DHSS/DSDS Central Office by phone, in person, or by mail. Contact information for the DHSS/DSDS Central Office was provided in the public notice.

The public was informed via public notice that comments would be accepted by MHD directly via mail or email and contact information for MHD was provided in the public notice. The public notice included the mailing address, email and contact information used to receive comments from the public, and provided the following contact information: MO HealthNet Division, P.O. Box 6500, Jefferson City, MO 65102-6500, Attn: MO HealthNet Director, Email: AskMHD@dss.mo.gov. Per the notice, complete copies of the amendment application were also available on the MHD alerts and public notice webpage at https://mydss.mo.gov/mhd/alerts, or by request from the DHSS/DSDS Central Office; by phone at (573) 526-8557, in person at 912 Wildwood Drive, Jefferson City, MO 65102; or by mail at P.O. Box 570, Jefferson City, MO 65102-0570.

On August 8, 2024, the State notified in writing the federally recognized Tribal Government known as the Urban Indian Organization of the State's intent to submit a waiver amendment application. No comments were received in response.

A 30-day public comment period was provided from August 23, 2024, through end of business day September 23, 2024. No public comments were received in response.

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

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

7. Contact Person(s)

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

Last Name: Kremer

First Name: Glenda

Title: Assistant Deputy Director

Agency: Missouri Department of Social Services, MO HealthNet Division

Address: 615 Howerton Court

Address 2:
PO Box 6500

City:
Jefferson City

State: **Missouri**

Zip:
65102-6500

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

Fax:
(573) 526-4651

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

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

Last Name:
Highland

First Name:
Melanie

Title:
Division Director

Agency:
Department of Health and Senior Services, Division of Senior and Disability Services

Address:
912 Wildwood

Address 2:
PO Box 570

City:
Jefferson City

State: **Missouri**

Zip:
65102-0570

Phone:
(573) 526-3626 **Ext:** ☐ **TTY**

Fax:
(573) 751-8687

E-mail:
Melanie.Highland@health.mo.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions

of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Moore

First Name: Josh

Title: Division Director

Agency: Missouri Department of Social Services, MO HealthNet Division

Address: 615 Howerton Court

Address 2:

City: Jefferson City

State: **Missouri**

Zip: 65109

Phone: (573) 526-4267 **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:

When a participant's personal care needs surpass the 49-hour limit, staff shall implement the following actions:

1. Utilization of Backup Plans and Natural Supports
• Staff will defer the participant to their documented backup plan and/or natural support network to maintain care continuity.

2. Provision of Community Resources and Options
• Staff will provide participants with comprehensive information regarding community-based services and resources.
• Assistance will be offered to help participants make necessary contacts to secure additional supportive services that promote independence, health, and welfare.

3. Referral for ICF/ID Waiver Services
• If the participant meets diagnostic criteria for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) waiver, staff will supply participants with contact information to their local Department of Mental Health Regional Office.

4. Area Agency on Aging (AAA) and Additional Resources
• Staff will supply participants with contact information for their local Area Agency on Aging (AAA) and other relevant community resources.
• Participants will be informed that AAAs offer alternative services comparable to the ADW waiver, including home-delivered meals, respite, personal care, and household chores.

Of the 850 participants currently receiving personal care services, 32 will be affected by this amendment.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The State ran out of space in I-1-a to include the following:

In accordance with section 12006 of the 21st Century CURES Act and state and federal requirements, an Electronic Visit Verification (EVV) system is required for Personal Care service providers in the Independent Living Waiver. The state regulation regarding EVV compliance criteria and responsibilities is available at 13 CSR 70-3.320. This regulation is inclusive of all Personal Care services delivered through the Medicaid program.

Methods for electronic verification include, but are not limited to, the use of mobile applications with Global Positioning System (GPS) capabilities, telephony from a landline, fixed devices and biometric recognition.

Exceptions (manual adjustment or update to a EVV record) and manual visit entries (entry of a paper record into the EVV system) both require the provider agency to enter justification documentation into the EVV system. Information shall include date and time of the entry and/or update, the reason for the entry and/or update, and the identification of the person making the entry and/or update.

Manual visit entry shall be utilized only when the EVV system is unavailable or when documented circumstances make usage of the system impossible or impractical. Justification documentation must support any instance of human error and such errors must be readily identifiable. Repeated instances of human error are subject to audit. These paper records shall be maintained by the provider agency and made available upon request by the State.

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 Health and Senior Services, Division of Senior and Disability Services

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

DSDS is responsible for the administrative functions required for the operation of the waiver program, conducting level of care evaluations, overseeing the development and management of person-centered service plans (PCCP), authorization of services, review and annual reassessment of PCCP, and developing Individual Services Budget. DSDS is also responsible for submitting a statistically valid case record review of the waiver to MHD annually.

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

Appendix A: Waiver Administration and Operation

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

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

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver administration. Thus this section does not need to be completed.

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:
As indicated in sections 3 and 4 of this appendix, no non-Medicaid or non-State agency performs waiver administration. Thus this section does not need to be completed.

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an

individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of quarterly meetings held during the waiver year to discuss

performance measure findings from DHSS' quarterly reviews. Numerator: Number of quarterly meetings held during the waiver year to discuss performance measure findings from DHSS' quarterly reviews. Denominator: Total number of quarterly meetings held.

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

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 paid waiver service units that were delivered based on authorized units of service. Numerator: Number of paid waiver service units that were delivered based on authorized units of service. Denominator: Total number of paid waiver service units.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **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 policies, procedures and rules reviewed by MHD, that are applicable to the waiver. Numerator: Number of policies, procedures and rules reviewed by MHD, that are applicable to the waiver. Denominator: Total number of policies, procedures and rules applicable to the waiver released by the operating agency.

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Issues which require individual remediation may come to MO HealthNet Division's (MHD) attention through review of Division of Senior and Disability Services (DSDS) reports, as well as through day-to-day activities of MHD, e.g., review/approval of provider agreements, utilization review and quality review processes, complaints from MO HealthNet participants related to waiver participation/operation by phone or letter, etc. MHD addresses individual problems related to delegated functions as they are discovered by contacting DSDS and advising them of the issue. A follow-up memo or email is sent from MHD to DSDS identifying the issue and if appropriate a corrective action resolution. While some issues may need to be addressed immediately DSDS is required to provide a written response to MHD that specifically addresses the issue identified by MHD. Written documentation will be maintained by both MHD and DSDS and as needed discussions will be included at the quarterly meeting. Any trends or patterns will be discussed and resolved as appropriate. Individual problems that are part of the report process will be included in the appropriate reports.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☒	**Disabled (Physical)**	18	64	
	☐	**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**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Initial entry into the Independent Living Waiver (ILW) is limited to persons with physical disabilities between the ages of 18 and 64 and who live in a private residence. Individuals who are receiving ILW services when they turn 65 may choose to continue to participate in the ILW for as long as they maintain the ability and still desire to self-direct their personal care attendant services. Individuals with a cognitive impairment must have the onset of the cognitive impairment on or after age 22. Individuals must be willing and able to self-direct their own care have the capability to hire, train, supervise, direct, and fire personal care attendant.

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:

Individuals who are receiving Independent Living Waiver (ILW) services when they turn 65 may choose to continue to participate in the ILW. As long as they meet Medicaid and LOC requirements and are able to continue self-directing their services. Each year at reassessment ability to self-direct is evaluated and between each assessment providers are required to report any concerns regarding ability to self-direct.

A current or potential Consumer Directed Services (CDS) participant is required to have the ability to direct his/her own care. Per Section 208.903.1.(4), RSMo. Section 208.900(2), RSMo defines “consumer directed” as the hiring, training, supervising, and directing of the personal care attendant by the consumer, regardless of age of participant. DSDS staff will reassess any participant when concerns of self-direction are identified. DSDS staff will administer a St. Louis University Mental Status (SLUMS) exam, complete the Self-Direction Participant Questionnaire, and as necessary gain the opinion of the participant’s health care provider through the use of the Healthcare Professional Inquiry form. Based upon these findings, if the participant is deemed no longer able to self-direct, the participant will be given the option to be transitioned into in-home services model Home and Community Based Services (HCBS).

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Specify the percentage: [ ]

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1150
Year 2	1150
Year 3	1150
Year 4	1150
Year 5	1150

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

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

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

◉ **Not applicable. The state does not reserve capacity.**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

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

waiver:

It is the State's intent to have adequate slots that will prevent the need for a waiting list. However, should a waiting list become necessary, the following protocol shall be used.

Individuals are enrolled based upon the individual meeting the nursing home level of care and criteria specified in this waiver. A high level of unit authorization is representative of individuals who have the greatest need in the State. In the event all slots are filled during a waiver year, priority of available slots will be given to those with the greatest need. Individuals will be enrolled based upon the number of potential units authorized in the task areas listed below, with the largest potential number of units indicating the highest level of need. If individuals have the same level of potential authorized units in the task areas listed below, the date of referral will be used.

Bathing
Bowel/Bladder Routine
Catheter Hygiene
Ostomy Hygiene
Meal Prep/Eating
Turning/Positioning
Assist with Toileting
Dressing/Grooming
Assistive with Transfer Device
Mobility/Transfer

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)*:

- ○ **Section 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)

- ☐ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- ☐ **Pregnant Women (42 CFR § 435.116)**
- ☐ **Infants and Children under Age 19 (42 CFR § 435.118)**
- ☐ **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 section 1902(a)(10)(A)(ii)(XIII)) of the Act)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 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:

MO HealthNet for Families-Adult (MHF), 42 CFR 435.110;
MO HealthNet for Pregnant Women (MPW), 42 CFR 435.116; and
MO HealthNet for Kids (MHK), 42 CFR 435.118.

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 period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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 period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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 an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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

Division of Senior and Disability Services (DSDS) staff, at a minimum, meet the following experience and educational requirements.
One or more years of experience as an Associate Social Services Specialist (SSS I), formerly Adult Protective and Community Worker (APCW), or Bachelor's degree. (Substitutions may be allowed.)
Position definitions of those performing the initial evaluations are as followed:
Associate Social Services Specialist (SSS I) (formerly APCW I): This is entry-level professional social service work in the Department of Health and Senior Services (DHSS) providing protective services and/or coordinating in-home services on behalf of senior and/or adults with disabilities.
Associate Social Services Specialist (SSS I) (formerly CSW I): This is entry-level professional social service work in the Children's Division of the Department of Social Services providing protective services on behalf of children and families in instances of abuse, neglect, or exploitation.

Allowable substitutions: OR a bachelor's degree from an accredited college or university; OR A Registered Nurse (RN) who is licensed and in good standing in Missouri; OR A Licensed Practical Nurse who is licensed and in good standing in Missouri with 1 or more years of experience working as an LPN. One or more years of experience as Social Services Specialist; OR Multilingual; Four or more years of experience with the Division of Senior and Disability Services or an Area Agency on Aging.

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.

In order to be eligible for entry to the Independent Living Waiver, individuals must meet nursing facility level of care (LOC) as specified in the Code of State Regulation (CSR) at 19 CSR 30-81.030. Points are assessed and assigned based on the amount and degree of assistance needed by the individual.

The LOC categories are: (1) Behavioral: repeated behavioral challenges that affect their ability to function in the community. (2) Cognition: performance in remembering, making decisions, organizing daily self-care activities, as well as understanding others and making self-understood. (3) Mobility: the ability to move from one place or position to another. (4) Eating: the ability to eat and drink, including the use of special nutritional requirements or a specialized mode of nutrition. (5) Toileting: ability to complete all tasks related to toileting including the actual use of the toilet room (or commode, bedpan, urinal), transferring to on/off the toilet, cleansing self, adjusting clothes, managing catheters, and managing incontinence episodes. (6) Bathing: full body shower or bath. (7) Dressing and Grooming: the ability to dress, undress, and complete daily grooming tasks. Dressing may also include specialized devices such as prosthetics, orthotics etc. (8) Rehabilitation: physician ordered rehabilitation therapy (speech, occupational, physical), points are based on frequency of services. (9) Treatments: physician ordered medical care or management that requires additional hands-on assistance. (10) Medication Management: the ability to safely manage their medication regimen. (11) Meal Preparation: the ability to prepare a meal based on the capacity to complete the task. (12) Safety: identification of a safety risk associated with a visual impairment, unsteady gait, past institutionalization, past hospitalization, and age. Scoring Methodology: any combination of points which meets the LOC specified in 19 CSR 30-81.030 qualifies an individual to meet LOC. Based on the criteria established in each category, points are assigned in each of the twelve categories in three point increments: 0 points: No conditions reported or observed, no assistance needed only set up or supervision need, no therapies or treatments ordered, no difficulty in vision, falls or recent problems with balance. 3 points: Mental conditions exhibited in the past, requires supervision in decision making, occasional limited or moderate assistance needed, has been institutionalized, therapies ordered less than daily, severe difficulty with vision, fallen and has current problems with balance. 6 points: Mental or behavior conditions and symptoms currently exhibited, requires monitoring by a physician or licensed mental health professional, moderate to maximum assistance needed, therapies ordered daily, treatments needed, no vision, balance issues and fallen in last 90 days. 9 points: Mental conditions and symptoms currently exhibited, requires monitoring by a physician or licensed mental health professional, displays poor decision making and requires total supervision, total dependence on others or maximum assistance needed, therapies ordered more than once per day. Additionally, four automatic qualifiers are included in the eligibility criteria: (1) no discernable consciousness, unable to make any decisions (2) total dependence to eat (3) bed-bound (4) age 75 or older with a safety score of six. These four pieces of the criteria termed as "triggers" are a "common sense" approach for individuals that should automatically meet LOC due to their full dependence on others. Waiver applicants will be directly contacted to schedule the initial assessment. Upon meeting LOC, a person-centered approach is taken to determine the specific services available for authorization based on established service authorization guidelines. The initial assessment is completed and entered into the InterRAI HC in the HCBS electronic case record within 15 business days of contact. The InterRAI HC utilizes behind the scenes decision tree algorithms based on the twelve categories outlined in this paragraph. Reevaluations of LOC will utilize the InterRAI HC with the same algorithms determining continued LOC eligibility utilizing the same twelve categories outlined in this paragraph.

The InterRAI HC has been designed to be a user-friendly, reliable person-centered assessment system that informs and guides comprehensive care and service planning in community-based settings around the world. It focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences. When used on multiple occasions, it provides the basis for an outcome-based assessment of the person’s response to care or services. The InterRAI HC can be used to assess persons with chronic needs for care, as well as with post-acute care needs (e.g., after hospitalization or in a hospital at home situation).

The InterRAI HC has been designed to be compatible with the suite of InterRAI assessment and problem identification tools. Such compatibility advances continuity of care through a seamless assessment system across multiple health care settings and promotes a person-centered evaluation rather than fragmented site-specific assessments.

The Home Care assessment system, or HC, was developed to provide a common language for assessing the health status and care needs of frail elderly and individuals with a disability living in the community. The system was designed to be compatible with the Long-Term Care Facility system that was implemented in US nursing homes in 1990-91.

Target Population
The HC was developed for use with adults in home and community-based settings. The instrument is generally used with the frail elderly or persons with disabilities who may or may not be receiving formal health care or supportive services.

The HC was designed to highlight issues related to functioning and quality of life for community-residing individuals. Information is gathered in the following domains: Identification Information, Intake and Initial History, Cognition, Communication and Vision, Mood and Behavior, Psychosocial Well-Being, Functional Status, Continence, Disease Diagnoses, Health Condition, Oral and Nutritional Status, Skin Condition, Medications, Treatment and Procedures, Responsibility, Social Supports, Environmental Assessment, Discharge Potential and Overall Status, Discharge, and Assessment Information.

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

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:

An interview is scheduled with a potential waiver participant by a qualified individual as specified in B-6-c. Initial evaluations are conducted face-to-face, usually at the participant's residence, and reevaluations are usually conducted face-to-face but may be performed by phone by any Division of Senior and Disability Services (DSDS) staff meeting the qualifications established in B-6-c. Sufficient information is obtained during this interview to complete the Level of Care (LOC) evaluation utilizing the HCBS electronic case record as described in the administrative section of the application.

Waiver applicants will be directly contacted to schedule the initial assessment. The initial assessment is completed and entered into the InterRAI HC in the HCBS electronic case record. The InterRAI HC utilizes behind the scenes decision tree algorithms based on the LOC criteria outlined in B-6-d. Reevaluations of LOC will utilize the InterRAI HC with the same algorithms determining continued LOC eligibility utilizing the same LOC criteria outlined in B-6-d.

The HCBS electronic case record requires LOC reassessments be completed within 365 days of the initial assessment or the last reassessment. Within the HCBS electronic case record the service plan and prior authorization are tied to a current assessment. This design will ensure that services are not reimbursed unless there is a current assessment.

In addition to the DSDS State staff, waiver vendors may complete the InterRAI HC reassessment. The actual LOC determination will be made by the State, based on the information in the InterRAI HC. Designated DSDS staff receive notification electronically 90 days prior to the date the reassessments are due to allow adequate time to schedule a reassessment with the participant to complete the InterRAI. Designated DSDS staff will be responsible for assigning the reassessments and monitoring this report on a monthly basis to ensure all reassessments are completed within 365 days of the last assessment. In addition, DSDS Central Office staff will monitor reassessment reports to ensure they are completed within required timeframes. Should a backlog develop, the state will address it through remediation based on the specific issue.

Should there be any overdue reassessments due to State staff, the error will be addressed and remediated on an individual basis. Participant services will not be impacted due to any state issue with reassessments. Overdue reassessments as a result of a participant being unavailable will be handled based on the individual situation of the participant (i.e., hospitalization; nursing facility; out of state visiting family, etc.). Services may not resume until the participant receives a reassessment. Waiver services for individuals who refuse a reassessment will be terminated. 10 business days prior to termination of services, the participant is mailed a fair hearings notice. Following receipt of the fair hearing notice, the participant may contact DSDS to schedule the reassessment or pursue a fair hearing.

The vendor is required to report to DSDS when the care needs of the participant change. DSDS has further discussion with the participant to discuss any potential care plan changes. Pursuant to state statute, at any time the vendor owner, operator, or any employee is aware of, or suspects any abuse, neglect, or exploitation has occurred, the vendor is required to immediately report that information to the Department of Health and Senior Services' Central Registry Unit (CRU) for further investigation. In addition, DSDS conducts, no less than annually, case record reviews on a statistically valid sample of waiver participants. This includes reviewing the care plan and all supporting documentation in the participant's case record.

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:

Any Division of Senior and Disability Services (DSDS) staff meeting the qualifications established in B-6-c can complete a reevaluation. A registered nurse (RN) or an individual with the same qualifications as those established in Section B-6-c.

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):*

Division of Senior and Disability Services (DSDS) staff receive a report of participants 90 days prior to the date the reassessments are due to allow adequate time to schedule a reassessment with the participant to complete the InterRAI. Designated staff in the regions will be responsible for assigning the reassessments and monitoring this report on a monthly basis to ensure all reassessments are completed within 365 days of the last assessment. In addition, DSDS Central Office staff will monitor reassessment reports to ensure they are completed within required timeframes.

Any reassessment completed and submitted to the State by Home and Community Based Services (HCBS) providers shall be reviewed by and approved by State staff.

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:

Per 42 CFR §441.303(c)(3), DSDS 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. Records regarding the evaluation/reevaluation are maintained in the HCBS electronic case record.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
#&% of applicants for whom there is an indication that svc may be needed in the future whose records show LOC determinations were done. N:#of applicants for whom there is an indication that svc may be needed in the future whose records show LOC determinations were done. D:# of applicants for whom there is an indication that svc may be needed in the future whose records were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **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.

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 participants for whom LOC processes & instruments were applied as described in the approved waiver to determine initial participant LOC.
Numerator:Number of participants for whom LOC processes & instruments were applied as described in the approved waiver to determine initial participant LOC.
Denominator:Total number of participants with an initial LOC determination reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

When an error is discovered during a Division of Senior and Disability Services (DSDS) case record review or one is identified in a DSDS report, a DSDS supervisor reviews the error and works with the worker who completed the assessment to appropriately address the error. General methods of remediation may include re-training staff, discussions during area and regional meetings and/or change in DSDS policy or procedure.

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**

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

At the initial evaluation qualified individuals as specified in B-6-c explain to the potential waiver participant the services available through the Independent Living Waiver (ILW). Individuals can then make an informed choice between receiving services through a nursing facility or the Home and Community-Based Services, State Plan and/or waiver. The form that documents participant choice is the Participant Choice Statement. Individuals are required to document his/her choice via a dated signature on the form, which is also signed and dated by the individual performing the assessment. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years in the HCBS electronic case record. Participants are also provided with a signed copy.

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.

Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years in the HCBS electronic case record. Participants are also provided with a signed copy.

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):

Interpreter services are available at no cost to the individual. Forms and information will be made available in alternate languages as needed and appropriate, interpretive language services will be provided for effective communication between DSDS staff and persons with Limited English Proficiency to facilitate participation in, and meaningful access to services.

Applicants for, or recipients of, services from the Department of Health and Senior Services (DHSS) or services funded through DHSS, are treated equitably regardless of age, ancestry, color, disability, national origin, race, religion, sex, sexual orientation, or veteran status. Appropriate interpretive services will be provided as required for the visually or hearing impaired and for persons with language barriers. Anyone who requires an auxiliary aid or service for effective communication, or a modification of policies or procedures to participate in a program, service, or activity of DHSS should notify DHSS as soon as possible, but no later than 48 hours before the scheduled event.

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	**Case Management**		
Extended State Plan Service	**Personal Care**		
Supports for Participant Direction	**Financial Management Services**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Specialized Medical Equipment and Supplies**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*

Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained; ongoing monitoring of provision of services included in participant's care plan; review of the care plan; identification of abuse, neglect, and/or exploitation; assist in acquisition of necessary assistive technology services and/or devices and advocate for consumers by arranging for services with individuals, businesses and agencies for the best available service within limited resources; and ensuring participants have full access to a variety of services and service providers to meet participants' specific needs, regardless of funding source. Providers of Case Management may not provide direct Personal Care service to the participant.

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

Case Management providers shall provide at least one hour of Case Management per month. For billing purposes, one unit of Case Management equals one month.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Center for Independent Living, Personal Care Agencies, Financial Management Providers, Area Agencies on Aging

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Center for Independent Living, Personal Care Agencies, Financial Management Providers, Area Agencies on Aging

Provider Qualifications

License *(specify):*

This section does not apply.

Certificate *(specify):*

This section does not apply.

Other Standard *(specify):*

Regardless of the provider type, all case management providers must meet the same qualifications, and must comply with the requirements, philosophy and services as specified in Sections 208.900 through 208.930, RSMo and Code of State

Regulation (CSR) 19 CSR 15-8.

In order to qualify for a written Participation Agreement (contract) with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC) the provider shall demonstrate, via the process described in the Entity Responsible For Verification section, that the provider meets the following requirements:

(1) Have a philosophy that promotes the consumer's ability to live independently in the most integrated setting or the maximum community inclusion of persons with physical disabilities. This philosophy includes the following independent living services: advocacy, independent living skills training, peer counseling, and information and referral services.

(2) Programs and procedures are in place for training and orientation of consumers concerning their responsibilities of being an employer, including but not limited to: skills needed to recruit, employ, instruct/train, supervise and maintain services of personal care attendants and preparation and verification of time sheets.

(3) Procedures are established for the maintenance of a list of individuals eligible to be a personal care attendant, if a consumer requests assistance in recruitment. Procedures must ensure each attendant employed by a participant or on the eligible list is registered, screened, and employable pursuant to the Family Care Safety Registry (FCSR), the Employee Disqualification List (EDL) and applicable state laws and regulations.

(4) Procedures are established for educating the participant and the attendant of his or her responsibility to comply with all provisions of section 208.900 to 208.930, RSMo, the regulations promulgated there under in Code of State Regulation (CSR)19 CSR 15-8, and the participation agreement.

(5) Procedures are established for addressing inquiries and problems received from participants and personal care attendants.

(6) Have the capacity and procedures are established to provide fiscal conduit services (Financial Management Services), including but not limited to: performing, directly or by contract, payroll and fringe benefit accounting functions for consumers, including the transmission of the individual payment directly to the personal care attendant on behalf of the consumer and filing claims for MO HealthNet reimbursement.

In order to maintain the written contract with the department, a provider shall comply with the qualification provisions noted above and shall:

(1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial reports and annual audit submitted to the department; and

(2) Demonstrate a positive impact on consumer outcomes regarding the provision of personal care assistance services as evidenced on accurate quarterly and annual service reports submitted to the department;

(3) Implement a quality assurance and supervision process that ensures program compliance and accuracy of records; and

(4) Comply with all provisions of sections 208.900 to 208.927, and the regulations promulgated hereunder by Code of State Regulation (CSR)19 CSR 15-8.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Social Services, Missouri Medicaid Audit and Compliance Unit

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Personal Care

HCBS Taxonomy:

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

Service Definition *(Scope):*

Personal Care services that are provided when personal care services furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not differ from Personal Care services furnished under the State Plan. Additional Personal Care services provided under the waiver are not limited in amount or frequency. State Plan and waiver Personal Care services are self-directed, with the participant having the authority and responsibility to recruit, hire, train, monitor, and fire his/her attendant. Provider qualifications specified in the State Plan apply. Personal Care services may be provided outside the participant's home.

This waiver service is only provided to individuals age 21 and over. All medically necessary Personal Care services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

Personal care services will be provided up to 49 hours per week, per participant.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Personal Care Attendant

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Personal Care Attendant

Provider Qualifications

License *(specify):*

This section does not apply.

Certificate *(specify):*

This section does not apply.

Other Standard *(specify):*

Personal care attendants must meet the following qualifications:
1. Be at least eighteen (18) years of age;
2. Be able to meet the physical and mental demands required to perform specific tasks required by a particular consumer;
3. Agree to maintain confidentiality;
4. Be emotionally mature and dependable;
5. Be able to handle emergency type situations; and
6. Not be legally responsible for the participant (i.e., spouse or guardian).

These standards are set forth in Section 208.900 through 208.930, RSMo., and Code of State Regulation (CSR)19 CSR 15-8.

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

The personal care attendant is an employee of the waiver participant but only for the time period authorized for reimbursement through the waiver program with federal or state funds and is never the employee of the waiver provider, Department of Health and Senior Services (DHSS), or the state of Missouri.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Financial Management Service provider chosen by the participant must verify the attendant meets all provider requirements.

Frequency of Verification:

Prior to employment.

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:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
12 Services Supporting Self-Direction	12010 financial management services in support of self-dir
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services and function that assists participant or their designee to facilitate the employment of staff by the participant, by performing as the participant's agent:

Assist the participant to verify worker citizenship status

Collect and process EVV records of support workers

Process payroll, withholding, filing and payment of applicable Federal, state and local employment-related taxes and insurance

Ensure the personal care attendant is registered with the family care safety registry as provided in Section 210.900 to 210.936

Financial management services also include information and assistance to the participant or designee in arranging for, directing and managing services. The service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. This service does not duplicate other waiver services, including case management.

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**

☐ **Remote/via Telehealth**

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	Financial Management Service provider

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Financial Management Service provider

Provider Qualifications

License *(specify):*

Does not apply

Certificate *(specify):*

Does not apply

Other Standard *(specify):*

Any provider who meets the “Provider Qualifications” specified in the Waiver application, and is capable of performing all requirements of the service definition may enroll as a Financial Management Services (FMS) provider. This includes, but is not limited to, Centers for Independent Living, Personal Care providers, financial institutions such as banks and credit unions.

Financial Management Service providers must comply with the requirements, philosophy and services as specified in Sections 208.900 through 208.930, RSMo and state regulation 19 CSR 15-8.

In order to qualify for a written Participation Agreement (contract) with the Department of Social Services, the FMS provider shall demonstrate, via the process described in the Entity Responsible For Verification section, that the provider meets the following requirements:

(1) Have a philosophy that promotes the consumer's ability to live independently in the most integrated setting or the maximum community inclusion of persons with physical disabilities. This philosophy includes the following independent living services: advocacy, independent living skills training, peer counseling, and information and referral services.

(2) Programs and procedures are in place for training and orientation of consumers concerning their responsibilities of being an employer, including but not limited to: skills needed to recruit, employ, instruct/train, supervise and maintain services of personal care attendants and preparation and verification of time sheets.

(3) Procedures are established for the maintenance of a list of individuals eligible to be a personal care attendant, if a consumer requests assistance in recruitment. Procedures must ensure each attendant employed by a participant or on the eligible list is registered, screened, and employable pursuant to the Family Care Safety Registry (FCSR), the Employee Disqualification List (EDL) and applicable state laws and regulations.

(4) Procedures are established for educating the participant and the attendant of his or her responsibility to comply with all provisions of section 208.900 to 208.930, RSMo, the regulations promulgated there under in state regulation 19 CSR 15-8, and the participation agreement.

(5) Procedures are established for addressing inquiries and problems received from participants and personal care attendants.

(6) Have the capacity and procedures are established to provide fiscal conduit services (financial management services), including but not limited to: performing, directly or by contract, payroll and fringe benefit accounting functions for consumers, including the transmission of the individual payment directly to the personal care attendant on behalf of the

consumer and filing claims for MO HealthNet reimbursement.

In order to maintain the written contract with the department, a provider shall comply with the qualification provisions noted above and shall:

(1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial reports and annual audit submitted to the department; and

(2) Demonstrate a positive impact on consumer outcomes regarding the provision of personal care assistance services as evidenced on accurate quarterly and annual service reports submitted to the department;

(3) Implement a quality assurance and supervision process that ensures program compliance and accuracy of records; and

(4) Comply with all provisions of sections 208.900 to 208.927, and the regulations promulgated hereunder by state regulation 19 CSR 15-8.

Financial Management Service Providers (FMS) providers must also meet the following requirements:

- Experience completing accounting and payroll activities including processing EVV records and issuing paychecks to employees and making the necessary state, local and federal deductions.
- Develops, implements and maintains an effective payroll system that adheres to all related tax obligations, both payment and reporting.
- Agency/organization must apply for and receive approval from the Internal Revenue Service to be an employer agent in accordance with Section 3504 of the IRS Code and IRS Revenue Procedure 70-6.
- Has an Internal Revenue Service federal employee identification number dedicated to the financial management service.
- Conducts criminal background checks and age verification on personal care attendants.
- Is accessible to assist consumers: has a telephone line with convenient hours, fax and internet access and a customer services complaint reporting system. Includes alternative communication formats.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Social Services, Missouri Medicaid Audit and Compliance Unit.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home and community, and avoid institutionalization. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant.
Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All adaptations or improvements shall be provided in accordance with applicable State or local building codes. Adaptations or improvements shall not be provided to living arrangements that are owned or leased by waiver providers. When an institutionalized individual is being transitioned back to the community and waiver environmental accessibility adaptations are deemed necessary and authorized, the adaptations may begin within the 180 consecutive days prior to community transition. Such adaptations cannot be billed until the date the individual leaves the institution and enters the waiver.

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

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

Adaptations or improvements to the home may be substituted for personal care services when identified as a cost-effective alternative on the participant's care plan. Purchases covered by this category are limited to $5,000 per five year period of time.

If the $5000 per five year period limit is reached, DSDS and the Case Management provider will assist participants in accessing various community resources to meet the need.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Contractor

Provider Qualifications

License *(specify):*

This section does not apply.

Certificate *(specify):*

This section does not apply.

Other Standard *(specify):*

The Financial Management Services (FMS) provider will assist the participant in obtaining bids for the authorized service to ensure the most efficient use of waiver funds. The FMS provider must ensure that all providers of environment accessibility adaptation are qualified and meets all state and local licensure and or certifications requirements as applicable. The contractor must have applicable business license and meet applicable building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS provider.

Frequency of Verification:

Prior to service delivery

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

HCBS Taxonomy:

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

14 Equipment, Technology, and Modifications	14031 equipment and technology

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

14 Equipment, Technology, and Modifications	14032 supplies

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

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

Service Definition *(Scope):*

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. The agreed to purchase price shall cover the costs of training the waiver participation in the operation and maintenance of equipment. Coverage shall also include the costs of maintenance and upkeep of equipment.

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

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

Specialized medical equipment or supplies may be substituted for personal care services when identified as a cost-effective alternative on the participant's care plan. With the exception of incontinences supplies, purchases are limited to $5,000 in a five year period of time.

If the $5000 per five year period limit is reached, DSDS and the Case Management provider will assist participants in accessing various community resources to meet the need.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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 and Supply Dealer and/or Retail/Wholesale Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Medical Equipment and Supply Dealer and/or Retail/Wholesale Business

Provider Qualifications

License *(specify):*

This section does not apply.

Certificate *(specify):*

This section does not apply.

Other Standard *(specify):*

The Financial Management Services (FMS) provider will assist the participant in obtaining bids for the authorized service to ensure the most efficient use of waiver funds. The FMS provider must ensure that all providers of medical equipment and supplies are qualified and meets all state and local licensure and or certifications requirements as applicable. Enrolled with Medicaid as a state plan Durable Medical Equipment Provider or be registered and in good standing with Missouri Secretary of State's office.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS provider

Frequency of Verification:

Prior to service delivery

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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 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.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

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

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

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

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

All positions that have contact with the enrolled participant require a Missouri background investigation through DHSS. These background investigations are completed by the provider on their employees.

Providers are responsible for requesting state criminal/background investigations on staff providing direct care to waiver eligible participants prior to employment. Providers request these investigations through the Family Care Safety Registry (FCSR) which helps protect participants by compiling and providing access to background information.

Criminal background checks may be submitted directly to the MO State Highway Patrol in accordance with requirements of Chapter 43,RSMo;

Employee Disqualification List (EDL) checks may be submitted directly to the Missouri Department of Health and Senior Services (DHSS) as provided in section 192.2490, RSMo;

The Registry accesses the following background information from Missouri Data ONLY, and through the following cooperating state agencies:

1) State criminal background records maintained by the Missouri State Highway Patrol
2) Sex Offender Registry information maintained by the Missouri State Highway Patrol
3) Child abuse/neglect records maintained by the Missouri Department of Social Services
4) The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
5) The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
6) Child-Care facility licensing records maintained by the Missouri Department of Health and Senior Services
7) Foster parent licensing records maintained by the Missouri Department of Social Services

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

Missouri Medicaid Audit & Compliance (MMAC) is responsible for monitoring providers to assure that background investigations are conducted as required by statute and regulation. This monitoring will be conducted during regular monitoring visits, requested technical assistance visits and complaint investigations.
Monitoring providers for compliance will be conducted during regular monitoring visits and complaint investigations. MMAC verifies every three years during the post payment review.

Providers are required to perform abuse registry screening on all staff employed by the provider. MMAC Unit ensure that mandatory investigations have been conducted.

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

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

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

The Department of Health and Senior Services (DHSS) is responsible for maintaining the Employee Disqualification List (EDL) and the Family Care Safety Registry (FCSR)(explained in C-2-a).

No person is allowed to be employed to work or allowed to volunteer in any capacity in any Independent Living Waiver (ILW) program that left or was discharged from employment with any other employer due to abuse or neglect to patients, participants or clients and the dismissal or departure has not been reversed by any tribunal or agency. Each ILW provider is required to complete an EDL screening and a criminal record review through the Missouri State Highway Patrol for all new applicants for employment in positions involving contact with participants.

The ILW provider is also required to make periodic checks of the EDL to determine whether any current employee, contractor or volunteer has been recently added to the list. DHSS produces an annual list in January of each year. Updates are added to the web site each quarter which list all individuals who have been added to or deleted from the EDL during the preceding three months.

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

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

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

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

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

  Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

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

- ◉ **Other policy.**

  Specify:

  Relatives, except for spouses or children under the age of 18, may be paid for providing waiver personal care attendant services; the relative can live in the same residence. Legal guardians may not be paid for providing waiver personal care attendant services to a waiver participant. Waiver case management providers are required to monitor the services provided to a waiver participant at least monthly. Provision of services is also monitored as described in Appendix I.

  The payment of services is limited to the actual amount authorized through the service plan, which is prior authorized in the MMIS.

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

Interested providers contact Missouri Medicaid Audit & Compliance (MMAC), Provider Enrollment Unit. Any provider who meets provider qualifications is allowed to enroll. Specific criteria regarding programs and provider enrollment requirements are available to all individuals through MMAC at http://mmac.mo.gov.

There are several statewide Associations for the home and community-based services industry which provide additional information to association members regarding provider enrollment information.

There are no timeframes for provider enrollment. Open enrollment is ongoing throughout the year. Providers may contact the Missouri Medicaid Audit and Compliance (MMAC) Provider Enrollment Unit for information on how to enroll. Enrollment timeframes vary and are dependent upon the volume of requests for enrollment being processed by the Provider Enrollment Unit.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- ○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ○ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
  - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance,

complete the following. Where possible, include numerator/denominator.

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

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

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

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

Performance Measure:
Number and percent of non-licensed/non-certified waiver providers who continue to meet waiver provider requirements. Numerator: Number of non-licensed/non-certified waiver providers who continue to meet waiver provider requirements. Denominator: Total number of non-licensed/non-certified waiver providers enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMAC Provider Enrollment

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 new non-licensed/non-certified waiver providers who meet initial waiver provider requirements prior to serving participants. Numerator: Number of new non-licensed/non-certified waiver providers who meet initial waiver provider requirements prior to serving participants. Denominator: Total number of new non-licensed/non-certified waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMAC Provider Enrollment

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 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 ILW personal care providers that submitted documentation that state and waiver training requirements were met. Numerator = Number of ILW personal care providers that submitted documentation that state and waiver training requirements were met. Denominator: Total number of ILW personal care providers required to submit training documentation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMAC Provider Enrollment Files

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

ii. Remediation Data Aggregation

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

Responsible Party*(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 in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☐ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☐ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *(see Appendix D-1-d-ii)***

☐ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☐ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☐ **Facilitates individual choice regarding services and supports, and who provides them.**

☐ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

○ **No, the waiver does not include provider-owned or controlled settings.**

○ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☐ **Each individual has privacy in their sleeping or living unit:**

- ☐ **Units have entrance doors lockable by the individual.**
- ☐ **Only appropriate staff have keys to unit entrance doors.**
- ☐ **Individuals sharing units have a choice of roommates in that setting.**
- ☐ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☐ **Individuals have the freedom and support to control their own schedules and activities.**

☐ **Individuals have access to food at any time.**

☐ **Individuals are able to have visitors of their choosing at any time.**

☐ **The setting is physically accessible to the individual.**

☐ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Participant Choice Statement and the associated Prior Authorization - Care Plan from the HCBS electronic case record in conjunction with the InterRAI HC MO Version

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

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

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

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

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

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

☐ **Social Worker**
Specify qualifications:

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

Any Division of Senior and Disability Services (DSDS) staff who meets, at a minimum, the following experience and educational requirements as described in B-6-c can develop a Person-Centered Care Plan (PCCP).

Staff receive both on-the-job training and classroom style training. Initially, each region provides on-the-job training to their staff which includes the following:

Review the policy manual
Shadow a seasoned coworker to observe the process
contacting the participant to schedule the face-to-face appointment
completion of the InterRAI HC
development of the PCCP
contacting the provider the participant has chosen
authorizing the PCCP in the HCBS electronic case record
sending a copy of the PCCP to the participant
providing a copy of the PCCP to the participant's medical professional

Staff are required to attend a week-long training (32 hours).
Staff receive approximately 6 to 8 hours of training on the assessment tool - InterRAI HC. Each section is discussed to establish a better understanding of the intent of the questions, definitions, process, and coding. Some questions are followed by a written scenario for each attendee to code. Questions and discussion follow.

Staff receive approximately 2 hours of training for the development of a PCCP. A brief overview of the services, eligibility requirements and focusing on unmet needs is part of the discussion. The attendees are divided into groups where they discuss a written scenario and determine the services the participant is eligible to receive, keeping in mind the cost cap.

The supervisor of the new assessor may shadow the new employee to provide additional overview/training.

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a**

clear and accessible alternative dispute resolution process;

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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.

Qualified individuals who perform the assessment will review the list of available Home and Community Based Services (HCBS) (both State Plan and Waiver services) with each participant. The HCBS electronic case record provides all users a comprehensive definition of each HCBS care plan which can then be provided to the participant and others involved in the development of the care plan. The participant signs the completed Participant Choice Statement to indicate their participation in the development of, and agreement with, the care plan. The signed document also provides a phone number of the appropriate DSDS Person Centered Care Plan Unit (PCCP) for the participant to utilize when changes in circumstances occur that may affect the care plan. Discussions are then held with the participant to determine if care plan changes are necessary.

The Division of Senior and Disability Services (DSDS) recognizes participants and other individuals are an integral part of the service planning process. The participant is informed by qualified staff as specified in D-1-a, that they may elect to include anyone they want to contribute to the discussions and the actual plan. Prior to initiation of the service plan development, services available through the Independent Living Waiver are discussed with the participant and their invitees. Participant rights and responsibilities are discussed with the participant along with the appeal process.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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) DSDS staff develop a care plan at the time of the initial assessment or reassessment with the participant, and anyone they choose to be present. The participant is contacted to schedule an appointment at their convenience, in regard to time and location, for the participant. The scheduling and completion of the initial assessment must be completed within 15 business days of the date the referral was received. This process allows the participant to have anyone they choose present during the care planning process. The care plan is updated when the Division of Senior and Disability Services (DSDS) staff are contacted by the provider or participant when there is a change in the participant's circumstances or needs.

(b) The InterRAI HC is a comprehensive internationally recognized home care assessment that supports service plan development including the needs, preferences, goals, risks, and health status of the participant.

(c) The services available through the Independent Living Waiver are described/explained to the participant and other attendees during the assessment and service plan development process. The actual provider is selected through the participant's choice and provider availability.

(d) During the comprehensive assessment, the goals, needs, (including health care needs), and preferences of the participant are identified and addressed in the service plan. The InterRAI HC is a comprehensive assessment tool which not only determines the Level of Care (LOC) of the individual, but looks at the participant risks, strengths, and needs (including health care needs) as related to community living.
Although necessary at times, independent contact with other individuals shall not compromise the rights and preferences of the participants. If additional information gathered during the design of a service plan creates a discrepancy with the expressed wishes of a participant, additional discussions and documentation shall take place. Additional issues, to include health care needs, may be identified that require the participants to be informed of any potential barriers, which will prompt additional discussion about how to address these issues. Appropriate referrals are made to other resources necessary to assist the participant in achieving optimal independence. When the participant receives services from other agencies, coordination of services to assure continuity of care without duplication of services may be necessary. DSDS staff and the waiver provider will assist participants in the implementation of services authorized or other areas identified within the service plan.

(e) DSDS staff, the waiver provider staff, and the participant coordinate the implementation of the service plan, including non-waiver services.

(f) DSDS staff, the participant, and the FMS provider are responsible for implementation and compliance with the service plan. The right of self-determination shall necessitate the individual's participation and approval of the service plan.

(g) Service plans are reviewed by qualified individuals as warranted, at least annually, at a minimum.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☐ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☐ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☐ **A specific and individualized assessed need for the modification.**
- ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☐ **Informed consent of the individual.**

☐ **An assurance that interventions and supports will cause no harm to the individual.**

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.

During the assessment, evaluation and care planning process risks are assessed such as: identifying support systems or lack thereof, and confusion factors. Once the assessment/evaluation process identifies possible risk factors and needs, a determination is made as to whether or not these factors will be alleviated through service planning, or if referrals should be made to and coordinated with other community supports. These needs are noted on the Participant Choice Statement in order to document what actions are taken to mitigate any risk problems. DSDS staff is trained to facilitate a conversation regarding back-up plan arrangements with every participant. Back-up plans are developed specific to the participant's needs. During the assessment process, participants are made aware of the need to have in place back-up plans to address contingencies such as emergencies, natural or human-made disasters, failure of the waiver provider staff to show up as scheduled, etc. Types of back-up arrangements that could be utilized are discussed and identified with the participant and documented on the assessment tool, which is a companion document to other service planning documents. These arrangements could include but are not limited to: awareness of emergency contact number for the waiver provider, contact names/phone numbers of individuals that could be reached 24/7, listing of family members or others that are willing/ready to act as back-up aides or assist participant in various ways, arrangements with someone to check on participants on an at least daily basis, and registration with utility companies to ensure utilities are returned to service quickly, if necessary.

Additionally, all qualified providers are subject to universal reporting of abuse, neglect, or exploitation. Missouri statute also includes specific language in certain sections that mandate various entities to report abuse, neglect, or exploitation. When abuse, neglect, or exploitation indicators are noted during assessment/evaluation process, a report is to be made to the DHSS Central Registry Unit as outlined in G-1-b. Response to the report is further defined in G-1-d. Strategies to mitigate identified risk of abuse, neglect, or exploitation to the participant are discussed with the participant by DSDS staff and developed within a protective service plan as outlined in G-1-e.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A list of eligible providers is reviewed with the participant during the initial service planning process. Participants may choose the provider they want from this list. Participants can also access a MO HealthNet Provider Search function on the DSS/MHD website (www.dss.mo.gov). Participant choice is documented on the Participant Choice Statement by the participant's signature. A copy of the statement documenting participant choice is maintained in the HCBS electronic case record.

A list of all qualified providers is available to the participant upon request, at reassessment, or anytime they request a provider change. New providers are added to the provider list on a continuous and ongoing basis.

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):

The Division of Senior and Disability Services (DSDS) staff develop the initial service plan and review the service plan no less than annually. A change to the service plan may be requested by anyone, including the participant, when there is a change in the participant's needs. However, all service plan changes are subject to the review and approval of DSDS staff and include discussion with the participant.

Additionally, DSDS staff completes a statistically valid number of record reviews, no less than annually, on an ongoing basis to assure service plans are completed in accordance with waiver policies and procedures. Reports are produced and sent to MO HealthNet Division (MHD) no less than annually, which document the outcome of the reviews. MHD will review the report no less than annually. Supporting documentation will be available to MHD upon request.

In addition to the annual statistically valid sampling review performed by DSDS, MHD also conducts their own review annually based upon 25 randomly selected participants. The review by staff from MHD ensures individuals receiving waivered services had a service plan in effect for the period of time services were provided. The review process also ensures that the need for services that were provided was documented in the service plan, and that all service needs in the plan were properly authorized.

At any time, MHD may conduct a record review of the service plan by accessing the HCBS electronic case record. However, making the service plan subject to the approval of the state Medicaid agency (MHD) will normally be through reports generated by DSDS to negate the need for redundancy and duplication of efforts related to record reviews.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, 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:

Waiver provider and participant

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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) The Division of Senior and Disability Services (DSDS) staff are responsible for monitoring and assuring the implementation of the service plan.

(b)/(c) Services are furnished in accordance with the service plan. DSDS staff may contact the participant to assure services have started. The waiver provider is required to monitor, at least monthly, the provision of services to ensure services are being delivered in accordance with the care plan. DSDS staff are to be contacted immediately regarding any critical issues identified during the monitoring.

Participants have access to Waiver services identified in the care plan by documenting referrals made, acceptance of participants by the provider, and documentation to include attempts to secure other services.

At a minimum, annual direct, in-person contact is made with the participant. Information discussed and provided to participants annually during the assessment and reassessment process includes contact information for DSDS staff. Once this is discussed with the participants and or their guardian, they acknowledge they understand by signing the form.

Back-up plans are effective. Participants are instructed to contact the provider if a caregiver does not arrive as scheduled, if it becomes a continuous problem, DSDS will intervene as necessary. Contact with the participant ensures care was safely and adequately provided as reported by the participant and/or responsible party in the absence of the provider.

Participant health and welfare is assured: During the assessment process, it is determined whether participant's health and welfare can be assured through provision of Waiver services. The care plan can be adjusted to meet the participant’s needs.

Participants exercise free choice of providers. As a component of Participant Choice Statement – which is secured from the participant at least annually, the participant is informed of their right to select any qualified provider. A list of qualified providers is available as needed or requested by the participant and/or responsible party or to explore other provider options.

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

Collection and Reporting of monitoring results:
Annually, DSDS conducts a case record review on a statistically valid sample of waiver participants. Any deficiencies identified during monitoring are reported as findings, and include corrective action plans, and follow-up activities.

No less than annually, MO HealthNet Division (MHD) Program Operations staff and DSDS Central Office staff meet to discuss the Quality Improvement Strategy described throughout the waiver.

DSDS Central Office staff and MHD staff review the performance measures and analyze corresponding reports generated by both agencies. DSDS and MHD review the outcome of the reports to ensure they are meeting the assurances specified throughout the application and what, if any, action may be necessary for remediation and or system improvement.

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

Recommendations for a system change may come from either agency; however, MHD will approve any changes to the Quality Improvement Strategy specified in the waiver application. Any changes in the Quality Improvement Strategy in the waiver application are implemented and monitored, as appropriate.

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

Although individual problems are remediated upon discovery, performance measures that are significantly lower than 100% may need to be addressed as a systemic issue. Implementation of system improvement will be a joint effort between DSDS and MHD. System change related to delegated activities will be the responsibility of DSDS and those

activities that are not delegated will be the responsibility of MHD. Follow-up discussions related to system improvement activities may be discussed at quarterly meetings but will be discussed no less than annually.

Systemic issues may require follow-up reports, policy, and or procedure changes, as well as staff and/or provider training. MHD and DSDS will analyze the effectiveness of system improvement activities through the Quality Improvement Strategy reports and or additional reports that may be recommended by DSDS and or MHD when significant areas of concern are identified.

As issues arise outside of the Quality Improvement Strategy (QIS), the State Medicaid Agency is in continuous contact with the operating agency through e-mail, phone, and ad-hoc meetings. Issues are discussed and resolution/remediation is determined as needed. Follow-up to these issues are monitored and are also discussed at Quarterly Quality Meetings.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants whose service plans identify and address the participant's assessed needs. Numerator: Number of participants whose service plans identify and address the participant's assessed needs. Denominator: Total number of participants whose service plans were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case record review

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants whose service plans indicate health and safety risk factors have been assessed and addressed. Numerator: Number of participants whose service plans indicate health and safety risk factors have been assessed and addressed. Denominator: Total number of participants whose service plans were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(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 = 95% confidence level with a +/- 5% margin of error.
☐ **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:

Performance Measure:
Number and percent of participants whose service plans indicate all personal goals have been assessed and addressed. Numerator: Number of participants whose service plans indicate all assessed personal goals have been assessed and addressed. Denominator: Total number of participants whose service plans were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **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: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants whose service plans were revised when the participant's needs changed. Numerator: Number of participants whose service plans were revised when the participant's needs changed. Denominator: Total number of participants whose service plans were reviewed that warranted revision due to changes in their needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **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 participants whose service plans were reviewed annually.
Numerator: Number of participants whose service plans were reviewed annually.
Denominator = Total number of participants whose service plans were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **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:

d. ***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 surveyed respondents indicating they received services by type/scope/amount/duration/frequency meeting the needs identified in their service plan. N: Number of surveyed respondents indicating they received services by type/scope/amount/duration/frequency meeting the needs identified in their service plan. D: Total number of surveyed respondents reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Reviews, off-site and Participant Survey

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

		95% confidence level with a +/- 5% margin of error.
☐ **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: 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:
 # and % of participants whose service plans include the participant's signature that specifies choice was offered between institutional care and waiver services.
Numerator: # of participants whose service plans include the participant's signature that specifies choice was offered between institutional care and waiver services.
Denominator: Total # of participants whose service plans were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **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 participants whose service plans include the participant's signature that specifies choice was offered among waiver services and providers.
Numerator: Number of participants whose service plans include the participant's signature that specifies choice was offered among waiver services and providers.
Denominator: Total number of participants whose service plans were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

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 = 95% confidence level with a +/- 5% margin of error.
☐ **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:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

When an error is discovered during a Division of Senior and Disability Services (DSDS) case record review or one is identified in a DSDS report, a DSDS supervisor reviews the error and works with the appropriate staff to address the error. General methods of remediation may include service plan revisions, re-training staff, discussions during area and regional meetings and/or change in DSDS policy or procedure.

If it is determined during the case record review, waiver services were not provided in accordance with the service plan, DSDS will request information from the provider as to why the services were not provided as specified in the care plan. General methods of remediation may include provider training, service plan changes and/or a formal letter to the provider requiring a corrective action plan to ensure services are provided in accordance with the care plan.

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**

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

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.

If it is determined during the assessment/evaluation process that a need exists for personal care attendant services, participants are advised of the consumer-directed model and the agency model. If the participant chooses the consumer-direction model and personal care attendant services are necessary over and above the State Plan maximum limit, they can receive extended Personal Care services through the Independent Living Waiver. Independent Living Waiver services that participants may self-direct are limited to personal care attendant services.

During this process, the individual is provided a description of responsibilities under the consumer-directed model, which includes: recruitment, hiring, training, and supervision of the attendant; willingness to employ attendants who are registered, screened, and employable pursuant to the Family Care Safety Registry, Employee Disqualification List, and applicable State laws and regulations; utilization of the Electronic Visit Verification (EVV) system; ensuring that units denoted in the EVV system are within the authorized amount; prompt notification to the Division of Senior and Disability Services (DSDS) or the FMS provider of changes in the participant's circumstances affecting the service plan and/or changes in the participant's information (address, phone number, etc.); and notification to DSDS staff or the FMS provider regarding any problems resulting from the quality of services rendered by the attendant.

When a participant chooses the consumer-direction model and functions as the employer, the FMS provider selected by the participant conducts fiscal conduit services, including, but not limited to, transmitting payment to attendants, applicable payroll taxes, etc.

FMS providers are required to support the waiver participant by providing training and orientation of the participants in the skills necessary to recruit, employ, instruct, supervise and maintain the services of attendants. If a participant has concerns about the training provided or feels that adequate support is not provided by the FMS provider, the participant is directed to contact DSDS. DSDS will assist the waiver participant and FMS provider in resolving the issue or will assist the waiver participant in selecting another FMS provider.

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

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.

Participants learn about participant directed options during the assessment/evaluation/service plan development conducted by Division of Senior and Disability Services (DSDS) staff, when needs are identified and ways of supporting the needs are discussed. The participant directed possibilities must be discussed with interested participants at this time. These discussions will include an explanation of the benefits of participant direction (hiring an attendant of the participant's choice, flexibility in scheduling the authorized services, etc.), responsibilities outlined in Appendix E-1 a. and the potential liabilities that may be involved in order to ensure the participant can make an informed choice on the services they wish to utilize to meet his/her agreed upon needs.

Information on participant direction opportunities is also provided by the Financial Management Services (FMS) provider. In addition, FMS providers are required to provide detailed training and orientation to participants regarding their responsibilities related to consumer directed services.

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:

Independent Living Waiver participants are allowed to elect a designee of their choice to direct their care, i.e., make decisions on hiring and firing attendants, make recommendations on the scheduling of the attendant, complete and review EVV records on behalf of the participant, as long as the participant retains the ability to self-direct. The designee may not be the paid personal care attendant. The designee must be capable of fulfilling the requirements of the program on behalf of and as directed by the participant. A monthly contact by the Financial Management Services (FMS) provider is intended to monitor all aspects of program participation, including actions taken by the designee, to ensure they are in the best interest of the 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
Personal Care	☒	☐

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:

Financial Management Services

○ **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:

Enrolled Financial Management Service (FMS) providers will provide services through the Fiscal/Employer Agent. Enrolled provider requirements will be published and placed on Missouri Medicaid Audit and Compliance (MMAC) website. Organizations interested in providing FMS services are required to submit a signed Provider Addendum to MMAC prior to enrollment to provide the service. The addendum identifies the waiver program under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements.

The FMS provider addendum and accompanying documentation are reviewed by MMAC and all assurances are satisfied prior to MMAC assigning the provider specialty. Once approved by MMAC, the FMS provider will be notified that they may begin providing FMS services.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Enrolled Financial Management Service (FMS) providers will be reimbursed a prior authorized per member per month amount through a claim submitted by the provider to the Medicaid Management Information System (MMIS).

The reimbursement rate for FMS provided through the ILW is based on cost analysis associated with the provision of this service. In addition, industry standards and information from other states for reimbursement of FMS were considered. Missouri also consulted with ILW providers regarding costs associated with FMS.

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:

FMS is required to utilize EVV to document services provided to Medicaid participants.

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:

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.

Missouri Medicaid Audit and Compliance (MMAC) verifies the Enrolled Financial Management Service (FMS) provider meets waiver standards and State requirements to provide FMS services prior to enrollment. These standards are also verified through a review process. FMS providers will be required to submit to MMAC an annual audit report that is completed by a licensed independent practitioner (Certified Public Accountant (CPA) licensed in the state of Missouri). This annual audit report should include all standard reports according to generally accepted accounting principles, which shall include but not be limited to Balance sheet, Statement of Revenue, Expenditures and Changes in Fund Balance (i.e. travel, supplies, rent, etc.), Budgetary Comparison Schedule and any relevant ownership and disclosure information to include shares distributed to stakeholders and the stakeholder's interest in company. For FMS providers, the audit must also include a review of all FMS payroll functions including state and federal tax calculations, reporting and payments. The audit will be reviewed by MMAC staff. MMAC will conduct reviews and verification of the providers' Electronic Visit Verification (EVV) records as well as the aides' background screening. A system of data collection and remediation will be implemented to address individual provider issues and identify opportunities for system changes.

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
Personal Care	☐
Case Management	☒
Environmental Accessibility Adaptations	☐
Financial Management Services	☒
Specialized Medical Equipment and Supplies	☐

☐ **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:

When an Independent Living Waiver participant voluntarily chooses to no longer self-direct or delegate the self-direction responsibilities of their personal care attendant services through the waiver, participation in this waiver as a whole will be terminated. The Division of Senior and Disability Services (DSDS) staff will advise the participant of the availability of agency-model personal care services, Aged and Disabled Waiver services (for individuals age 63 and above), Adult Day Care Waiver, Structured Family Caregiving Waiver, Brain Injury Waiver, and/or other community resources. If the participant chooses to utilize the agency-model services (State Plan or waiver), DSDS staff will provide a listing of eligible providers from which the participant selects their provider of choice. DSDS staff will then coordinate with the Waiver provider and the agency-model provider to ensure a smooth transition from Independent Living Waiver participant-directed waiver services to the state plan agency-model without loss of services during the transition period to assure participant health and welfare.

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.

When an Independent Living Waiver participant is deemed ineligible to continue to self-direct his/her personal care attendant services through the waiver, participation in this waiver as a whole will be terminated.

Involuntary termination of consumer-directed services could be precipitated by a participant's inability to continue directing their own care, persistent noncompliance with the service plan, intentional fraud of the program, abuse of the attendant or provider staff, and/or risks to health and safety cannot be mitigated. Ability to self-direct care will be established via the same criteria utilized to determine eligibility for entrance to the waiver.

In all cases, the Financial Management Service (FMS) provider will counsel the participant to assist in understanding the issues, let the participant know what corrective action is needed, and determining whether or not the participant can benefit from additional training. If the participant refuses to cooperate or the issue cannot be resolved, the FMS provider would notify the Division of Senior and Disability Service (DSDS) so that necessary services may be offered to the individual through agency-model services (state plan or waiver) or other community resources.

DSDS staff will then coordinate with the FMS provider and the State Plan agency-model, or waiver provider, to ensure a smooth transition from participant-directed services to the State Plan agency-model, or waiver provider, without loss of services during the transition period to assure participant health and welfare.

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	1150	
Year 2	1150	
Year 3	1150	
Year 4	1150	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 5	1150	

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:

There is no cost assessed to the participant. The FMS provider conducts the background check on the participant’s behalf. There is a one-time registration fee for the attendant to register with the Family Care Safety Registry.

☐ **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:

FMS is required to utilize EVV to document services provided to Medicaid participants.

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:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

During the assessment/service planning process, potential waiver participants are advised of their right to appeal and participate in a fair hearing when they are adversely impacted, i.e., denied services, feel their freedom of choice in selecting Home and Community Based Services (HCBS) vs. institutional services or provider(s) is denied, they are in disagreement with the level of care determination or service planning results, and/or is in disagreement when services are reduced, suspended or terminated. This information/process is discussed with the participant by the Division of Senior and Disability Services (DSDS). This information is also provided in writing to the participant when services are recommended; the participant will be requested to sign an acknowledgement that the appeal/fair hearing process has been explained to them.

In the event of an adverse action as described above, the waiver participant is advised verbally of the proposed action by DSDS. The participant also receives a written adverse action notice that specifies the proposed adverse action, their right to appeal the action and to request a fair hearing on the action, and confirmation the request for a hearing must be made within 90 days of receipt of the adverse action notice. The written adverse action notice also advises the participant if a hearing is requested within 10 calendar days of receipt of the adverse action notice, services will continue as authorized at that time pending the hearing decision.

Participants can appeal the adverse action and request a hearing in writing, or may verbally contact DSDS, who will assist in the completion of the request for hearing form and submit it to the Department of Social Services (DSS), Division of Legal Services (DLS) for the participant.

Copies of adverse action notices and requests for hearing are maintained in the HCBS electronic case record.

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**

- **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.

Do not complete this item.

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**

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

Do not complete this item.

- **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).

Do not complete this item.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

Critical incidents include physical abuse, sexual abuse, emotional/psychological abuse, financial exploitation, misappropriation of funds/property, falsification, neglect (by self, or by others), restraint, seclusion, restrictive interventions, serious injuries that require medical intervention, criminal victimization or activity involving law enforcement, death, and medication errors. Missouri statutes include a universal mandated reporting, stating that any person having reasonable cause to suspect that an eligible adult is experiencing abuse or neglect and in need of protective services shall report such information to the Department of Health and Senior Services (DHSS). This universal mandate has no statutory penalties for not reporting and contains no immunity for those who do report. Missouri statutes (192.2405, RSMo) also include specific language in certain sections that mandate various entities to report possible abuse and/or neglect or cause a report of possible abuse and/or neglect to be made to DHSS. The entities that are mandated to report are: adult day care worker; chiropractor; Christian Science practitioner; coroner; dentist; embalmer; employee of the Departments of Social Services, Mental Health, or Health and Senior Services; employee of a local area agency on aging or an organized area agency on aging program, emergency medical technician; firefighter; first responder; funeral director; home health agency or home health agency employee; hospital and clinic personnel engaged in the care or treatment of others; in-home services owner, provider, operator, or employee; law enforcement officer; long-term care facility administrator or employee; medical examiner; medical resident or intern; mental health professional; minister; nurse; nurse practitioner; optometrist; other health practitioner; peace officer; pharmacist; physical therapist; physician; physician's assistant; podiatrist; probation or parole officer; psychologist; or social worker. When any of these entities has reasonable cause to believe that a participant has been abused, neglected or exploited, they are to IMMEDIATELY after being made aware of such critical incidents report or cause a report to be made to the department. These mandated reporters who fail to report or cause a report to be made to DHSS within a reasonable time after the act of abuse or neglect are guilty of a Class A misdemeanor (198.070 and 192.2475, RSMo).
The methods of reporting include calling DHSS staff or the Adult Abuse Hotline 800# (this number is promoted on DHSS public information, brochure, posters, and website), making a report online at health.mo.gov/abuse, written correspondence with DHSS or through the Ask Us function on DHSS' website. All reports are logged in the APS case management system, regardless of the method utilized to report, in order to track all reports.

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.

The Division of Senior and Disability Services (DSDS) and waiver providers provide participants with information (verbally and in written format) about reporting policy and procedures for incidents at the time of enrollment, annually, and any time the waiver participant perceives that their rights and/or responsibilities have been violated. DHSS staff, DSDS staff, etc., instruct the waiver participant, legally responsible parties, and any informal caregivers about the types of critical incidents and all the methods/options for reporting incidents of abuse, neglect, or exploitation to DHSS. The Participant Choice Statement document the participants sign includes the sentence, "I understand I can call the toll-free hotline at 1-800-392-0210 to report abuse, neglect, or exploitation." This document is gone over thoroughly with participants at the initial authorization of Home and Community Based Services and at least annually thereafter.

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

The Department of Health and Senior Services (DHSS) is the mandated adult protective services agency in Missouri. Statute 192.2415, RSMo defines the investigatory authority of DHSS as limited to eligible adults with a protective service need. DHSS/DSDS staff shall investigate and offer protective services to all eligible adults when deemed appropriate. This shall include: 1) adults age 60 years or older who are unable to protect their own interests or adequately perform or obtain services which are necessary to meet their essential human needs, and 2) adults with disabilities between the ages of 18 and 59 who are unable to protect their own interests or adequately perform or obtain services which are necessary to meet their essential human needs. Reports may be received that would not fall within the scope of DHSS' authority but may be appropriately referred to another agency for assistance. Reports are registered by DSDS Adult Protective Services staff into the state's APS case management system. The following is applicable to waiver participants receiving services in their own home: Preliminary classification of reports is based on information received from the reporter at the point of intake. Classification is based on the level of harm or risk to the eligible adult, combined with the reported need to gather evidence. Class 1 reports contain allegations, which if true, present either an imminent danger to the health, safety or welfare of an eligible adult or a substantial probability that death or serious physical harm will result. Class I reports involve situations of a crisis or acute nature which are currently occurring and require immediate intervention and/or investigation to gather critical evidence. (Reporters are directed to contact the local law enforcement agency on reports involving allegations of homicide or suicidal threats). Class II reports contain allegations of some form of abuse, neglect, or exploitation of an eligible adult but do not allege or imply a substantial probability of immediate harm or danger. Situations described in a Class II report do not require an immediate response. DHSS staff are responsible for the investigative process. After receiving a report for investigation, DHSS staff 1) Review the report and the prior history of any and all pertinent persons involved in the report. 2) Conduct an investigation including such steps involving medical professionals or law enforcement for urgent situations; conducting interviews, (i.e., reporter, eligible adult, witnesses and the alleged perpetrator) conduction pertinent assessments, including decisional capacity, based on reported information; collecting/gathering records, documents and/or evidence that may need to be obtained to (dis)prove the allegations in the report; and involving agencies or entities (if any) that needs to be contacted to co-investigate or provide support. 3) Provide any necessary resource referrals and/or required interventions in an attempt to alleviate the eligible adult's level of risk and/or provide the eligible adult with enough support to remain in the lease restrictive environment when appropriate and with the eligible adult's consent. 4) Conclude the investigation using all information obtained as well as professional observation and judgement. This will include recording all contacts and activities related to the investigation in the case record. It will also include submitting a copy of the investigation and findings to the local police, local prosecutor, or DHSS Office of General Counsel when the information gathered substantiates the allegation. A copy of the report is also sent to the DHSS Employee Disqualification List staff when a referral to this list warrants consideration. 5) Policy requires that investigations are conducted and completed and findings/results entered into the APS case management system within a ninety (90) day period. Extensions of the ninety (90) day period are allowed based on individual case circumstances. Class I reports are to be forwarded to investigative staff within one hour of receipt; Class II reports are to be forwarded within 3 hours of receipt. In response to Class I reports, a face-to- face must be made as soon as necessary or possible within the 24 hours following receipt of a report to ensure the safety and well-being of a eligible adult. The 24-hour period will begin at the time the information is received by DSDS. Investigations of Class II reports shall be initiated within a period not to exceed 48 hours after receipt of the report or by close of business the first working day after a weekend or holiday. Investigators shall conduct a face-to-face interview as soon as possible within a period not to exceed 7 calendar days from the receipt of the report. Face-to-face visits may be waived in certain situations when approved by a supervisor including when: 1) The alleged incident was previously investigated within the last 6 months and no new information was provided during the initiation process that impacts the eligible adult's health, safety, or welfare. 2) The only allegation is self-neglect and the eligible adult has been assessed face-to-face by the APS Specialist within the past six months; and has a history of refusing services with no reported decline in abilities or change in circumstances. 3) There are reports of financial exploitation involving scams or reports from financial institutions regarding fraudulent charges/transactions and no protective service needed. 4) The eligible adult cannot be located after three attempts to complete a face-to-face visit or has moved out of state. 5) The eligible adult or household member has suspected infectious illness that would pose a risk to the APS Specialist's health or safety. 6) The eligible adult has died, is inaccessible (example: eligible adult is in hospital on ventilator), or is incarcerated. 7) The eligible adult has been moved to a stable, long-term facility and safe placement, and/or the eligible adult has sufficient services in place to mitigate risks. 8) The eligible adult refuses to talk with the APS Specialist after attempt(s) to contact have been made. A waiver participant for whom an investigation is being conducted is involved in the investigation and the subsequent intervention process or plan on an ongoing basis. State statutes specifically, 192.2435, 192.2500, and 192.2505, RSMo prohibit DHSS from disclosing the investigative results/reports to anyone other than the participant/legal representative upon request, the Attorney General's office to perform that office's constitutional or statutory duties, the Department of Mental Health for residents placed through that Department to perform its constitutional or statutory duties, the appropriate law enforcement agency to perform its constitutional or statutory duties, or the Department of Social Services

for individuals who receive MHD benefits to perform its constitutional or statutory duties.

During the initial visit all DSDS participants receive a notice regarding 42 CFR 160-164. This informs the participant that they may inspect and receive a copy of their information which could include a copy of their abuse/neglect/exploitation investigation report, if applicable.

In situations where the participant has requested to see the investigation report, contact is made with the requestor within three (3) working days notifying them of the receipt of their request. The requested information will be sent within forty-five (45) days of the notification letter or of the case closure.

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

DSDS is responsible for overseeing the operation of the incident management system. DSDS supervisors are required to review two (2) reports per employee per month for non-probationary employees and 100% of reports for probationary employees until those employees have case approval as well as periodic reviews of all other reports. This supervisory review determines if the staff person conducting the investigation has followed policy and procedure during the investigation, has communicated with all the necessary parties, and has documented the investigation correctly. This oversight is conducted on an ongoing basis. Additionally, the Supervisor, in an effort to assist in ensuring the on- going quality of the investigations will conference with staff on reports, read on-going records, and, as possible go on interviews with the investigator. The APS case management system is utilized to collect information on reports containing allegations of abuse, neglect, and/or exploitation (ANE) and to track occurrence/reoccurrence of ANE by reported adult, alleged perpetrator, and the allegation(s). This system is accessible to all investigating staff and can be utilized in the investigation process to track how similar allegations were handled in the past. DSDS is mandated to provide protective services for eligible participants to help prevent future reports by reducing the cause of the abuse, neglect, or exploitation through a variety of activities: financial/economic interventions, education, local community supports, in-home or consumer-directed services, use of the resources of other agencies/entities, and the periodic contacts required when an individual is placed under 'protective service' status with DHSS. Person-centered protective goals and objectives are developed and documented in the APS case management system.

Participant information is collected and compiled in the APS case management system. The methods of reporting include calling DHSS staff or the Adult Abuse Hotline 800# (this number is promoted on DHSS public information, brochure, posters and website), making a referral online at helath.mo.gov/abuse, written correspondence with DHSS or through the 'Ask Us' function on DHSS' website. All reports are logged in the APS case management system, regardless of the method utilized to report, in order to track all reports. Information gathered on abuse, neglect, and exploitation is used to prevent reoccurrence through education and changes in policy and procedures including but not limited to staff and provider training and public awareness.

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

Appendix G: Participant Safeguards

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

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

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

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

Typically waiver services are performed in the participant's home. Use of restraints or seclusion is not addressed by the Department of Social Services (DSS), MO HealthNet Division (MHD) or the Department of Health and Senior Services (DHSS) in this waiver program. Suspected inappropriate use of restraints or seclusion would be reported to DHSS through the same methods by which abuse and neglect is reported and investigated. Waiver providers and DHSS workers would recognize the use of restraints or seclusion and are mandated to report such. The suspected inappropriate use of restraints or seclusion would be detected through assessment, observation, and communication.

DSDS monitors use of any restraints though observation, reports of abuse, neglect and exploitation, and communication. DSDS conducts continuous and ongoing training regarding the identification of abuse, neglect, and exploitation, including the use of restraints and restrictive interventions.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

Typically, waiver services are performed in the participant's home. Use of restrictive interventions is not addressed by the Department of Social Services (DSS), MO HealthNet Division (MHD) or the Department of Health and Senior Services (DHSS) in this waiver program. Suspected inappropriate use of restrictive interventions would be reported to DHSS through the same methods by which abuse and neglect is reported and investigated. Waiver providers and DHSS workers would recognize the use of restrictive interventions and are mandated to report such. The suspected inappropriate use of restrictive interventions would be detected through assessment, observation, and communication.

DSDS monitors use of any restraints though observation, reports of abuse, neglect and exploitation, and communication. DSDS conducts continuous and ongoing training regarding the identification of abuse, neglect, and exploitation, including the use of restraints and restrictive interventions.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

Typically, waiver services are performed in the participant's home or accompanying the participant in community activities. These homes are owned/rented by the participant/caretaker. Provider staff make monthly contact with the participant and/or responsible party. Additionally, an annual reassessment is conducted by State staff. Vendor staff are mandated reporters of abuse and neglect, which includes unauthorized restraint and seclusion. Possible incidents of seclusion will be documented and reported to the Central Registry Unit (CRU) at DHSS if abuse, neglect, or exploitation is suspected.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

- **Medication Management and Follow-Up**

Do not complete this section

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

- **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).

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

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants with credible evidence of ANE, &/or unexplained deaths referred to an investigative entity for follow-up. Numerator: Number of waiver participants with credible evidence of ANE &/or unexplained deaths referred to an investigative entity for follow-up. Denominator: Total number of waiver participants with such incidents.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of pts whose records document the pt/guardian received information/education on how and to whom to report abuse/neglect/exploitation (ANE) and other critical incidents. Numerator: # of pts whose records document the pt/guardian received information/education on how and to whom to report ANE and other critical incidents. Denominator = Total # of pts whose records were reviewed.

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

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

		Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **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:
 # and % of hotline investigations regarding substantiated allegations of ANE that resulted in a referral/safety plan to prevent future occurrences. Numerator: # of hotline investigations regarding substantiated allegations of ANE that resulted in a referral/safety plan to prevent future occurrences. Denominator: Total # of hotline investigations regarding substantiated allegations of ANE.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Reviews

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Data Source (Select one):
Other

If 'Other' is selected, specify:
Hotline Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **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 hotline reports for waiver participants that were resolved and closed within required timeframes. Numerator: Number of hotline reports for waiver participants that were resolved and closed within required timeframes. Denominator: Total number of hotline investigations reviewed for waiver participants.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **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 hotline reports for waiver participants resulting in an investigation initiated within required timeframes. Numerator: Number of hotline reports for waiver participants resulting in an investigation initiated within required timeframes. Denominator: Total number of hotline investigations reviewed for waiver participants.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **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:

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

Performance Measures

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

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

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

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

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

		Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error.
☐ **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):*

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants receiving monthly case management monitoring, addressing their health care needs through monthly contacts.
Numerator: Number of waiver participants receiving monthly case management monitoring addressing their health care needs through monthly contacts.
Denominator: Total number of waiver participants authorized case management whose records were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMAC Provider Monitoring

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 =

		90% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

When an error is discovered during a Division of Senior and Disability Services (DSDS) case record review or one is identified in a DSDS report, a DSDS supervisor reviews the error, and works with the appropriate worker to address and remediate the error. General methods of remediation may include: service plan revisions, re- training staff, discussions during area and regional meetings and/or change in Division policy or procedure. Problems related to timely investigation of hotlines are addressed through staffing and or staff training and or policy and or procedures as deemed 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 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 Section 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 (QIS) 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

No less than annually, MO HealthNet Division (MHD) Program Operations staff and Department of Health and Senior Services (DHSS) Program Oversight staff meet to discuss the Quality Improvement Strategy described throughout the AIDS Waiver (0197), Adult Day Care Waiver (1021), Aged and Disabled Waiver (0026), Brain Injury Waiver (1406), Independent Living Waiver (0346), Medically Fragile Adult Waiver (40190), and Structured Family Caregiving Waiver (1706).

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

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

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

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

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

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

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

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

ii. System Improvement Activities

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

b. System Design Changes

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

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

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Home and Community-Based Services Waiver Quality Management Strategy specified in the AIDS Waiver, Adult Day Care Waiver (ADCW), Aged and Disabled Waiver (ADW), Brain Injury Waiver (BIW), Independent Living Waiver (ILW), Medically Fragile Adult Waiver (MFAW) and Structured Family Caregiving Waiver (SFCW) is evaluated and updated no less than annually by MHD and DSDS. The process includes the review of performance measures, reports for performance measures, and remediation activities resulting from discovery. Annually, MHD and DSDS will determine if the QIS is providing the information and improvements necessary to meet the quality assurance performance measures as it relates to discovery, remediation and improvement activities. The committee will evaluate the QIS process annually to determine if the process is working. If it is determined additional input is necessary, DSDS and MHD will request input, by memos or meetings, from individuals involved in the authorization and/or delivery of AIDS Waiver, ADCW, ADW, BIW, ILW, MFAW, and SFCW services. This could include providers, other stakeholders and/or DSDS and MHD staff from other units within the agencies. Additionally, at least twice a year, the State conducts provider update meetings.

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).

Providers are required to maintain financial records, service documentation on each waiver participant, including name of participant, participant's MO HealthNet ID number, names of individual attendants who delivered the service, date service was rendered, and units of service provided. Services provided through the ILW must be prior authorized by DSDS staff; Prior Authorizations (PAs) are based on agreed upon services established during the service planning process. Authorized services are forwarded to MHD's fiscal agent via an electronic system. The authorization is provided to the provider selected by the participant, so the provider is aware of the authorization level and is equipped to train the participant in oversight of service delivery maintenance, etc. Providers are required by state regulation to have financial audits conducted annually by a Certified Public Accountant (CPA) licensed in the State of MO and submitted to MMAC within 150 days of the end of the providers' fiscal year.

Providers subsequently receive payment directly from MO HealthNet as reimbursement. After each billing cycle, MHD sends providers a Remittance Advice indicating the disposition of billed claims.

MMAC conducts periodic compliance audits in which documentation of services provided is reviewed to ensure services billed to MHD were provided and documented as required per state regulation. Selection of participants is determined by what providers are selected to be audited during the audit timeframe. MMAC will conduct an annual audit of ILW claims utilizing a statistically valid random sample methodology, with a 90 percent confidence level, to verify the sample test items (selected claims) accurately represent the universe of ILW claims for the review period. Providers with a history of problematic billing or complaints may be spot checked regarding those focused areas, in addition to receiving regular periodic audits. There are various reasons a spot check might occur. They could take place if a provider has problematic billing or takes place months after a standard audit to check if the provider has addressed previous issues, and/or made appropriate changes. Complaints against a provider or participant may trigger a spot check. The spot check audit process is the same as a standard audit, except the spot check audit has a smaller review time frame, usually 3-6 months. If issues are discovered, the audit time frame can be expanded. All claims within the chosen time period will be reviewed. There is no set standard as to how frequently spot check reviews are performed.

Reviews are normally performed on-site. A desk audit may be considered for providers with few participants in an outer area of the state when it's not economically feasible to travel long distances to the provider's location to obtain a small number of records. A desk audit entails requesting records by mail or fax. Providers are generally given 15 business days to produce records for a desk audit. Providers may then mail, fax or email records. Other than the records being sent in by the provider, the desk audit process is the same as off-site audits as stated for the following: The same in-depth review of records is completed and the same types and numbers of records are collected. Providers receive a call and a fax 24 hours prior to the audit. The fax contains a notice to audit and a partial list of participant names to be included in the audit. Once the audit has been finalized, the provider will receive a letter outlining violations and sanctions. The provider has 30 days to appeal and 45 days to submit a plan of correction. If the provider is found to not have violations, the provider will receive a "No Error Letter" stating they did not have violations.

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

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

Reviews of other providers are chosen based upon one or more factors, such as: work-plan, complaints/referrals/hotlines from the public, participants, other providers, other agencies such as licensing boards, Department of Health and Senior Services (DHSS), Department of Mental Health (DMH), Unified Program Integrity Contractor (UPIC), Recovery Audit Contractor (RAC) , Missouri Attorney General's Office (AGO), length of time since last audit, amount billed to the state, aberrant or quickly trending upward billing, analytic results showing suspicious or aberrant billing patterns and follow up to prior audits.

Utilization reports and trends are monitored between audits, and complaints or referrals can trigger an audit. Typically, audits are not performed on new providers within the first year.

Providers that are included in an audit with less than a year's worth of information would have all existing documentation reviewed. Review results statistics are available upon request.

Providers have the responsibility of ensuring they have documentation to support services prior to the filing of claims. The

State requires providers to retain documentation for six years but generally utilizes a three-year look-back period due to the availability of claims records in the State's Medicaid Management Information System (MMIS). Audits generally encompass a period of one year or less. The audit trail consists of documents located in the individual participant case records, the database utilized by DSDS for authorization of services, MHD, and providers. The case records contain the service plan (basis for the PA). Corresponding information is maintained in DSDS' database in order to electronically submit PA information to MMIS.

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

Documentation that supports provider billing is reviewed, such as service authorizations and provider monitoring logs. Verification of correct names in and out times, tasks performed, etc., are also reviewed. Background screenings are reviewed as part of MMAC's audit. Some provider types are required to do criminal background checks on employees, as some employees are required to be registered with the DHSS Family Care Safety Registry (FCSR); and some providers use this registry to perform checks. This varies depending upon the HCBS provider type, and other provider types as well. MMAC ensures employees are properly registered or have properly disclosed, and that initial and periodic screenings are performed, and Good Cause Waivers are applied for and received as necessary. When needed, employees can request a GCW from DHSS' Division of Regulation and Licensure (DRL). State Statutes require regulated health care employers obtain background screenings prior to hiring an employee; to include the FCSR. Individuals with certain type of criminal history findings identified in their background screening cannot be hired. Individuals who have been determined to have abused or neglected a resident, patient, client, or consumer; misappropriated funds or property belonging to a resident, patient, client, or consumer; falsified documentation verifying delivery of services to an in-home services client or consumer; or who have been found guilty of a Class A and B felony e.g., crimes against a person, robbery, child abuse, etc., are disqualified from being employed.

An individual who has been disqualified from employment has the right to apply for a GCW, which, if granted, would not correct or remove the finding, but would remove the hiring restriction and allow the individual to be employed. Upon submission of the GCW application to DRL, each case is reviewed by a panel for approval or denial. Each case is unique and may require additional information from the applicant, therefore, there is no set time when a GCW is determined.

Although this list is not exhaustive of the information taken in regard to the GCW application, the panel looks at: age of the applicant when the finding(s) occurred; circumstances surrounding incident(s);length of time since the incident(s)occurred to the time of the GCW request; applicant's work history; and any other information relevant to applicant's employment background or past actions indicating whether they would pose a risk to the health, safety or welfare of residents, patients or clients, etc. An individual who has been placed on DHSS' Employee Disqualification List (EDL) is not eligible to receive a GCW. Verification of screening is requested and reviewed to see if employees have been screened and if screenings were done timely. Participant's current plan of care and progress notes are reviewed to verify the plan is being followed and notes are being maintained. MMAC reviews for licensure qualifications, age qualifications, training and orientation qualifications, and other program specific qualifications, such as family members being personal care attendants or not. The scope of this process is not different as mentioned in other areas. Documents are either sent to MMAC by the provider (desk review) or scanned on-site at the provider's location (on-site review). MMAC personnel may access participant care plans through the HCBS electronic case record database. MMAC personnel are independently able to verify employees' registration and screening through the FCSR. MMAC expects providers to have access through the HCBS electronic case record or paper copies of participants' care plans and to have documentation of employee registration and screening (and application and granting of a GCW, if necessary). MMAC expects to see any and all other documentation to support the provider's billing, such as Electronic Visit Verification (EVV) records, physician's orders, nurse visit reports, etc. Refer to Main-B-Optional for information on services subject to EVV, methods, etc.

If the provider is found to not have violations, the provider will receive a "No Error Letter" stating they did not have violations. MMAC includes any identified violations in its final determination letter (audit findings).

MMAC reviews its state regulation (13 CSR 70-3.030) to determine appropriate administrative actions. Providers may have improperly paid money recouped or may face more serious administrative actions, such as participation or payment suspension, or termination. Providers may face less serious administrative actions in situations where Medicaid funds were properly paid and MMAC determines provider education or corrective action is more appropriate.

During an audit, MMAC checks every employee who has contact with any Medicaid participant who is part of the audit; there is no sampling. MMAC will sample participant and employee training and orientation documents during an audit. The number of sample records reviewed depends on the number of employees.

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

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

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

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

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMAC Provider Monitoring

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 = *90% or higher confidence level with a +/- 5% margin of error.*
☐ ***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 reimbursed in accordance with the reimbursement methodology specified in the approved waiver application. Numerator: Number of waiver service claims reimbursed in accordance with the reimbursement methodology specified in the approved waiver application. Denominator: Total number of paid waiver service claims.

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

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***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 paid waiver claims that had a prior authorization for services.
Numerator: Number of paid waiver claims that had a prior authorization for services.
Denominator: Total number of paid waiver claims.

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

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***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 paid waiver claims that are coded correctly for services included in the approved waiver. Numerator: Number of paid waiver claims that are coded correctly for services included in the approved waiver. Denominator: Total number of paid waiver claims.

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

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***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 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 waiver service rates paid that adhere to the rate methodology specified in the approved waiver application. Numerator: Number of waiver service rates paid that adhere to the rate methodology specified in the approved waiver application. Denominator: Total number of approved waiver service rates.

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing*

information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

State financial oversight exists to ensure claims are coded and paid in accordance with the reimbursement methodology in the approved waiver. Claims payment issues are the responsibility of MHD. MHD works to resolve payment issues as they are identified by MHD or DHSS. When an overpayment or underpayment has occurred, MHD recycles claims to pay or recoup appropriate funds. MMAC is responsible for provider reviews and identifying incorrect billings due to inadequate documentation, coding or unit errors, or other findings. Remediation occurs through changes in policies, procedures or MMIS system edits, or through the finalization of audits.

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

ii. Remediation Data Aggregation

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

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

The following is the foundation upon which rates were established, which provides the history for the basis of the development of rates in the Independent Living Waiver.

• Beginning with the April 2014 renewal of the Independent Living Waiver (ILW), the State separates the administrative function regarding assisting the ILW participant with ensuring the employability of an attendant; the collection and processing of timesheets for attendants; payroll processing; and the withholding, filing, and payment of applicable federal, state, and local employment-related taxes and insurance of the attendant from the personal care service in the ILW. With the implementation of the 21st Century Cures Act in 2021, Personal Care providers utilize Electronic Visit Verification (EVV) to capture information about the services provided, including service beginning and end times, which replaced the use of paper timesheets.

• The personal care service rate was based on the following factors: the attendant's wages, applicable employer taxes, and the personal care service rate according to the Missouri Department of Labor and Industrial Relations average wage for Personal Care and Service Workers plus all employer related taxes associated with the wage.

• Additionally, the reimbursement rate for Financial Management Services (FMS), provided through the ILW, was based on cost analysis associated with this service. The hourly rate for the payroll clerk and a half-time supervisor is based on occupational and wage estimates from the Missouri Department of Economic Development, Missouri Economic Research and Information Center (MERIC). Fringe benefits include payroll taxes (FICA, Medicare, SUTA, FUTA); health insurance; retirement funds; vacation, and sick time; paid holidays; life insurance; educational assistance as well as other employee benefits. The State used 49%, which was the amount used by Department of Health and Senior Services (DHSS) to estimate the fringe benefit costs for its comparable employees at that time. The estimated administrative cost was calculated at 22.5% of the Personnel and Fringe Benefits costs.

• The reimbursement methodology for case management is the minimum of 12 hours X minimum wage + employer taxes. This service is consistent with the provisions of §1902(a)30(A) of the Act (i.e., payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers).

• Regarding the reimbursement for Environmental Accessibility Adaptations, Specialized Medical Equipment, and Specialized Medical Supplies, the State requires three (3) estimates of the cost for the needed items. The State then reviews and approves one of the estimates. The State prior authorizes enough units to cover the actual cost of the item.

Annually thereafter, the Missouri Legislature reviews current rates and builds upon those rates.

Rates are reviewed annually during the legislative session through the State of MO annual budgeting/appropriation process. The State Legislature works independently with legislative budgetary and research staff and the input of the Missouri provider industry and participants to develop rate changes during the annual appropriations process and development of the State budget.

The Legislature makes the decision regarding any updates at this time. Both MO HealthNet Division (MHD) and Division of Senior and Disability Services (DSDS) provide historical utilization data to the Governors' budget office and appropriation committee that is used to apply any per unit rate changes.

Public comment is solicited through public notice as required in 42 CFR 447.205 though the process noted in (d)(2)(iv) of that CFR.

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

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

Special interest groups also track and monitor these hearings so that these members have the opportunity to testify. Participants and business entities have the opportunity to request rate increases as part of the annual legislative budget process. Any rate increase is subject to funding in the budget and may be increased if authorized by the State Legislature.

The Missouri State Legislature employs research staff who work in coordination with provider industry representatives and State agencies to determine inputs for development of rates.

The Missouri House of Representatives (MO HoR) has a standing Appropriations Committee for Health, Mental Health, and Social Services. This committee develops initial recommendations for rates and this information is sent to the standing Select Committee on Budget for final decisions regarding rates being sent for a vote decision before the MO HoR.

In the Missouri Senate, there is a standing Appropriations Committee which reviews information gathered by its members to determine rates, which then go before the Senate for vote.

Rates for waiver services are historically based on the following factors: Missouri hourly minimum wage, gas prices for the Midwest per gallon, the hourly amount for Independent Living Waiver services and the Consumer Price Index. The State legislature has the opportunity to ask questions from State agencies during the appropriations process.

The rates established by the MO Legislature are statewide rates and do not vary by provider. Current reimbursement rates can be found on MO HealthNet's website at http://dss.mo.gov/mhd/providers/pages/cptagree.htm. Information regarding payment rates is available upon request by the participant, through the MHD Constituent Services Unit or the MHD website. Requests may be made in writing to MHD or DHSS, by e-mail to Ask.MHD@dss.mo.gov, or by phone call to the MHD Constituent Services Unit.

Current rates are reasonable and remain sufficient to ensure continued access to quality of care, as there is provider competition for services, which allows for individual freedom of choice, and there is a lack of participant complaints regarding quality of care and inability to select/find a provider.

The State employed a contractor to conduct a rate study to ensure the rates are actuarially sound as it relates to quality access to service for all participants. The results of that rate study guide the State in making rate adjustments.

Funding for waiver services includes funding from the temporary 10 percentage point increase to the FMAP for Medicaid expenditures for home and community-based services provided under section 9817 of the American Rescue Plan Act of 2021 (ARP). Utilization of ARP funding will continue until all funds are exhausted, at which time funding of the State match will switch to all State general/tax revenue.

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

All services provided under this waiver are prior authorized by Missouri Department of Health and Senior Services' (DHSS) staff. The prior authorization is forwarded to the MO HealthNet Fiscal Agent. Providers of services bill claims for services directly to the MO HealthNet Fiscal Agent for claims processing. All claims are processed through a MMIS. Claims are checked against services prior authorized. Only authorized services are paid. Payment is made directly to the provider of service.

Appendix I: Financial Accountability

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

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

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

Select at least one:

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

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

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

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

Appendix I: Financial Accountability

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

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

DHSS staff determines participant eligibility for waiver services and develop/finalize the service plan. Based upon the participant's approved service plan, services are then prior authorized. This information is then electronically transferred to the MMIS for establishment of prior authorization for approved services against which all claims for payment from providers are compared.

The MMIS system incorporates an edit function that ensures services are only reimbursed to the provider for dates of service on which the participant is Medicaid eligible and only to providers who are enrolled on the date a service is delivered. No reimbursement will be made for units billed by the provider in excess of the authorized amount. Each time a claim is processed and paid, the number of units reimbursed to the provider is deducted from the number of units authorized.

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.

MMAC conducts compliance audits in which the documentation of services provided is reviewed to ensure that services billed to MHD were provided and documented as required per State Regulations. MMAC may arrange to conduct some interviews with waiver participants during monitoring. Discussion of whether services were actually delivered is held during these interviews. When investigating a complaint, MMAC staff will also verify that services were delivered as reported. Providers are required to have adequate documentation of service delivery prior to filing claims for reimbursement through MMIS.

Providers are responsible for reviewing electronic visit verification (EVV) records for accuracy prior to the filing of claims to MHD for reimbursement. Providers' procedures may include checking with Medicaid participants and their attendants to verify actual service delivery.

In accordance with section 12006 of the 21st Century CURES Act and state and federal requirements, a EVV system is required for Personal Care service providers in the Independent Living Waiver. The state regulation regarding EVV compliance criteria and responsibilities is available at 13 CSR 70-3.320. This regulation is inclusive of all Personal Care services delivered through the Medicaid program.

Methods for electronic verification include, but are not limited to, the use of mobile applications with Global Positioning System (GPS) capabilities, telephony from a landline, fixed devices and biometric recognition.

Exceptions (manual adjustment or update to a EVV record) and manual visit entries (entry of a paper record into the EVV system) both require the provider agency to enter justification documentation into the EVV system. Information shall include date and time of the entry and/or update, the reason for the entry and/or update, and the identification of the person making the entry and/or update.

Manual visit entry shall be utilized only when the EVV system is unavailable or when documented circumstances make usage of the system impossible or impractical. Justification documentation must support any instance of human error and such errors must be readily identifiable. Repeated instances of human error are subject to audit. These paper records shall be maintained by the provider agency and made available upon request by the State.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such

payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of***

the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

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

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

○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***

◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

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

Providers are not required to contract with OHCDS entities but may do so by choice. Any service in the waiver can be provided by an OHCDS. The participants have free choice of any qualified provider for the provision of any waiver service.

All persons or agencies which contract with an OHCDS to provide waiver services must meet the same requirements and qualifications as apply to providers enrolled directly with the Medicaid Agency. No OHCDS or contractor will be allowed to limit a participant's free choice of provider. Any entity wishing to be designated as an OHCDS must agree to bill the Medicaid program not 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. MMAC is responsible for enrolling all waiver providers as Missouri Medicaid providers. MMAC ensures that proof of license or other required credentials are received in order for the provider to enroll.

Financial Management Services (FMS) entities are designated as an OHCDS as long as they meet provider qualifications as specified in C- 3 and provide one service directly. Providers who meet the qualifications to enroll as an FMS provider may enroll directly and are not required to enroll as an OHCDS. Any qualified waiver providers who do not wish to contract with a Medicaid enrolled OHCDS may enroll directly with the Medicaid agency, through the normal provider application process. Direct service providers are not required to contract with an OHCDS. Participants have free choice of FMS providers both within the OHCDS and external to these providers. Participant may choose any qualified FMS provider to perform financial transactions on their behalf. The participant refers the attendant to the FMS provider of their choice to perform payroll functions. The participants have free choice of any qualified provider for the provision of a waiver service. The OHCDS is required to verify that the attendant with whom they contract meet the requirements specified in Appendix C for Attendant Care services. Qualifications of attendants are verified during provider reviews conducted by MMAC within the Department of Social Services (DSS), the Single State Medicaid agency. Quality oversight and monitoring of the OHCDS is administered by MMAC. Reimbursement is based on a fee schedule or acquisition costs. For example, the State requires three (3) estimates of the cost for the specialized medical equipment (SME) and supplies (SMS) and Environmental Accessibility Adaptations (EAA) items, and the state reviews and approves one of the estimates. The state prior authorizes enough units to cover the actual cost of the item. Attendant care services are reimbursed based on a statewide fee for service reimbursement rate. The reimbursement rate only includes the wages and applicable state and federal taxes. Financial oversight and monitoring of the OHCDS is administered by MMAC.

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 section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 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 text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 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 section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

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

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

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

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

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

The Department of Health and Senior Services (DHSS) is appropriated the state funds for the Independent Living Waiver (ILW). DHSS has filed an authorization letter with the Missouri Office of Administration indicating that MO HealthNet Division (MHD) is approved to code the state portion of its expenditures for ILW against DHSS appropriations from the state's General Revenue fund.

Claims are processed through the MMIS and adjudicated for payment. During the adjudication process, the Department of Social Services/Division of Finance and Administrative Services has been granted authority by DHSS, to issue warrants to draw down funds from the DHSS state appropriation. Providers are then paid directly by the MHD.

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

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

CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

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

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

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

○ ***Applicable***

Check each that applies:

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

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

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

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

Appendix I: Financial Accountability

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

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

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

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

Check each that applies:

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

☐ ***Provider-related donations***

☐ ***Federal funds***

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

Appendix I: Financial Accountability

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

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

- ◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

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

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

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

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

Appendix I: Financial Accountability

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

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

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

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

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

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

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

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	11083.20	39652.42	50735.62	42185.33	17908.23	60093.56	9357.94
2	11989.33	39881.20	51870.53	43704.00	18552.93	62256.93	10386.40
3	12938.80	40111.30	53050.10	45277.35	19220.84	64498.19	11448.09
4	13966.99	40342.72	54309.71	46907.33	19912.79	66820.12	12510.41
5	15091.00	40575.48	55666.48	48595.99	20629.65	69225.64	13559.16

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:
		Nursing Facility
Year 1	1150	1150
Year 2	1150	1150
Year 3	1150	1150
Year 4	1150	1150
Year 5	1150	1150

Appendix J: Cost Neutrality Demonstration

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

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

The average length of stay is 315 days. This number is based on the total waiver days of service (221,440 days) divided by the total number of waiver participants (315 participants) in waiver year April 26, 2020 through April 25, 2021.

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:*

• *Case Management (CM): Average number of users are projected to be 1,150. The projection for average number of CM users is based on the State expecting to fill all Independent Living Waiver (ILW) slots. Average units per user are determined, and trended forward based on one (1) unit being authorized annually for each ILW user. The average cost per unit trended forward from WY 2023 using the FY23 Market Basket Rate (MBR) of 3.60%. The average cost per unit trended forward from waiver year 2023 annual rate of $429.82 which was established July 1, 2023. CM rates increased during the COVID-19 pandemic. The State anticipates the reimbursement rates will level out, therefore, chose to use market basket rate rather than historical projection.*

Effective February 3, 2025, CM is moving to a monthly unit rather than annual. Average units per user will be 12 for all WYs. The average cost per unit for WY1 was calculated by dividing the current annual rate of $458.09 by 12. The State then projected the average cost per unit forward for subsequent WYs by using the FY24 market basket rate of 2.8%.

• *Personal Care (PC): Average number of users trended forward using the FY23 Market Basket Rate of 3.6%. The State chose to use the MBR, as the projections from WY 2017-2022 were greater than the anticipated for users of PC. The average units per user trended forward using the historical projection of 1.0% based on historical 372 data from WY17-22. The State used historical data to project average units as the projection reflects consistent growth which is anticipated for PC users. The average cost per unit trended forward from waiver year 2023 rate of $4.32 which was established July 1, 2023. PC rates increased at higher rates than usual during the COVID-19 pandemic. The State anticipates the reimbursement rates will level out, therefore, chose to use projections based on the FY23 Market Basket Rate (MBR) rather than historical 372 data.*

• *Financial Management Services (FMS): Average number of users is determined from the same projection for Personal Care (PC). This projection is based on each PC user being authorized for FMS. The projected average units per user is based on historical data averaged from WY 2017 through 2022 with an average of 9.16, rounding up to the next whole number of 10. The average cost per unit trended forward from waiver year 2023 rate of $148.69 which was established July 1, 2023. FMS rates increased during the COVID-19 pandemic. The State anticipates the reimbursement rates will level out, therefore, chose to use the FY 23 market basket rate rather than historical projection.*

• *Environmental Accessibility Adaptations (EAA): The State does not anticipate the average number of users to change over the 5-year waiver timeframe. The WY 2023 rate for EAA was established July 1, 2023. The average cost per unit will remain the flat rate of $100.00 and therefore will not reflect a trending increase.*
The average units per user are expected to increase over time. The projected expenditure for EAA users was trended forward using the FY23 Market Basket Rate of 3.60%. The State used Market Basket Rate to trend forward individual expenditures for EAA, as historical projections from WY 2017 through 2022 were greater than anticipated for users of EAA.

• *Specialized Medical Equipment (SME): Average number of users were determined using the FY23 Market Basket Rate (MBR) of 3.60% trending forward from WY 2022 372 report data. The State chose to use Market Basket Rate, as the historical projections from WY 2017 through 2022, 372 report data was greater than the anticipated for users of SME. The average units per user trended forward to cover the cost of the projected expenditure for each SME user. The WY 2023 rate for SME was established July 1, 2023. The projected expenditures for SME users trended forward using the Market Basket Rate of 3.60%. The State used Market Basket Rate to project individual expenditures for SME, as historical projections from WY 2017 through 2022 were greater than anticipated for users of SME. The average cost per unit will remain the flat rate of $100.00 and therefore will not reflect a trending increase.*

• *Specialized Medical Supplies (SMS): Average number of users were determined using the FY23 Market Basket Rate (MBR) of 3.60% trending forward from WY 2022. The State chose to use Market Basket Rate, as the historical projections from WY 2017 through 2022, 372 report data was greater than the anticipated for users of SMS. The average units per user trended forward to cover the cost of the projected expenditure for each SMS user. The WY 2023 rate for SMS was established July 1, 2023. The projected expenditures for SMS users trended forward using the Market Basket Rate of 3.60%. The State used Market Basket Rate to project individual expenditures for SMS, as historical projections from WY 2017 through 2022 were greater than anticipated for users of SME. The average cost per unit will remain the flat rate of $100.00 and therefore will not reflect a*

trending increase.

The source link used to obtain the market basket index rate: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data The State used the FY2023 Market Basket Rate for Skilled Nursing Facility.

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' was projected on the actual paid claims data for waiver years 2017-2022 The percentage of change for each year was calculated from which the average percent of change 0.58% was determined. The State then projected forward from the 2022 data using the average percentage change of 0.58% for each waiver year annually thereafter.

The State's reporting system is able to identify a participant's Medicare eligibility and whether or not the participant has Part D coverage. The expenditures for pharmaceutical claims included in the D' estimates were arrived at by excluding any claims that were processed/paid when the participant was eligible for Medicare Part D. Medicare Part D is not a factor in our determination of Factor D'.

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

When determining Factor G, a blended population of dually eligible (Medicare and Medicaid) vs. Medicaid participants was used to determine an actual comparison of population. This blended population was based on the percent of waiver (factor D) participants who were dual eligible (Medicare and Medicaid) and the percent that were Medicaid only. To determine the blended population expenditures the State pulled actual expenditures for G and G'. The data was then broken out by participants who were Medicaid eligible only, and participants who were dual eligible (Medicaid and Medicare). The State determined 36% of participants in WY2023 in the ILW were Medicaid only and 64% were dually eligible participants. For each factor (G & G'), the State then calculated 36% of the expenditures for Medicaid only participants and 64% of the expenditures for dual eligibles and added them together.

Factor G was trended forward using actual expenditures from waiver year 2023 at the FY23 3.6% Market Basket Rate. The waiver year 2023 Factor G value was $39,304.47. The source link used to obtain the market basket index rate: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data

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:*

When determining Factor G', a blended population of dually eligible (Medicare and Medicaid) vs. Medicaid participants was used to determine an actual comparison of population. This blended population was based on the percent of waiver (factor D) participants who were dual eligible (Medicare and Medicaid) and the percent that were Medicaid only. To determine the blended population expenditures the State pulled actual expenditures for G and G'. The data was then broken out by participants who were Medicaid eligible only, and participants who were dual eligible (Medicaid and Medicare). The State determined 36% of participants from WY2023 in the ILW were Medicaid only and 64% were dually eligible participants. For each factor (G & G'), the State then calculated 36% of the expenditures for Medicaid only participants and 64% of the expenditures for dual eligibles and added them together. Medicare Part D is not a factor in our determination of Factor G'.

Factor G' was trended forward using actual expenditures from waiver year 2023 at the FY23 3.6% Market Basket Rate. The waiver year 2023 Factor G' value was $16,685.27. The source used to obtain the market basket index rate: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data

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	
Case Management	
Personal Care	
Financial Management Services	
Environmental Accessibility Adaptations	
Specialized Medical Equipment and Supplies	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**526746.00**
Case Management	1 unit = 1 month	1150	12.00	38.17	**526746.00**	
Personal Care Total:						**10544956.80**
Personal Care	1 unit = 15 minutes	773	2940.00	4.64	**10544956.80**	
Financial Management Services Total:						**1233630.70**
Financial Management Services	1 unit = 1 month	773	10.00	159.59	**1233630.70**	
Environmental Accessibility Adaptations Total:						**24600.00**
Environmental Accessibility Adaptations	1 unit equals $100	6	41.00	100.00	**24600.00**	
Specialized Medical Equipment and Supplies Total:						**415800.00**
Specialized Medical Supplies	1 unit equals $100	228	18.00	100.00	**410400.00**	
Specialized					**5400.00**	

GRAND TOTAL: 12745733.50

Total Estimated Unduplicated Participants: 1150

Factor D (Divide total by number of participants): 11083.20

Average Length of Stay on the Waiver: 315

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Equipment	1 unit equals $100	6	9.00	100.00		

GRAND TOTAL: 12745733.50
Total Estimated Unduplicated Participants: 1150
Factor D (Divide total by number of participants): 11083.20
Average Length of Stay on the Waiver: 315

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
Case Management Total:						**541512.00**
Case Management	1 unit = 1 month	1150	12.00	39.24	**541512.00**	
Personal Care Total:						**11442845.70**
Personal Care	15-minute unit	801	2970.00	4.81	**11442845.70**	
Financial Management Services Total:						**1324373.40**
Financial Management Services	1 unit = 1 month	801	10.00	165.34	**1324373.40**	
Environmental Accessibility Adaptations Total:						**25200.00**
Environmental Accessibility Adaptations	1 unit equals $100	6	42.00	100.00	**25200.00**	
Specialized Medical Equipment and Supplies Total:						**453800.00**
Specialized Medical Supplies	1 unit equals $100	236	19.00	100.00	**448400.00**	
Specialized Medical Equipment	1 unit equals $100	6	9.00	100.00	**5400.00**	

GRAND TOTAL: 13787731.10
Total Estimated Unduplicated Participants: 1150
Factor D (Divide total by number of participants): 11989.33
Average Length of Stay on the Waiver: 315

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*
Case Management Total:						***556692.00***
Case Management	*1 unit = 1 month*	*1150*	*12.00*	*40.34*	***556692.00***	
Personal Care Total:						***12381131.58***
Personal Care	*15-minute unit*	*829*	*2999.00*	*4.98*	***12381131.58***	
Financial Management Services Total:						***1419994.10***
Financial Management Services	*1 unit = 1 month*	*829*	*10.00*	*171.29*	***1419994.10***	
Environmental Accessibility Adaptations Total:						***26400.00***
Environmental Accessibility Adaptations	*1 unit equals $100*	*6*	*44.00*	*100.00*	***26400.00***	
Specialized Medical Equipment and Supplies Total:						***495400.00***
Specialized Medical Supplies	*1 unit equals $100*	*245*	*20.00*	*100.00*	***490000.00***	
Specialized Medical Equipment	*1 unit equals $100*	*6*	*9.00*	*100.00*	***5400.00***	

GRAND TOTAL: ***14879617.68***

Total Estimated Unduplicated Participants: ***1150***

Factor D (Divide total by number of participants): ***12938.80***

Average Length of Stay on the Waiver: *315*

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
Case Management Total:						**572286.00**
Case Management	1 unit = 1 month	1150	12.00	41.47	**572286.00**	
Personal Care Total:						**13425860.76**
Personal Care	15-minute unit	859	3029.00	5.16	**13425860.76**	
Financial Management Services Total:						**1524295.50**
Financial Management Services	1 unit = 1 month	859	10.00	177.45	**1524295.50**	
Environmental Accessibility Adaptations Total:						**27600.00**
Environmental Accessibility Adaptations	1 unit equals $100	6	46.00	100.00	**27600.00**	
Specialized Medical Equipment and Supplies Total:						**512000.00**
Specialized Medical Supplies	1 unit equals $100	253	20.00	100.00	**506000.00**	
Specialized Medical Equipment	1 unit equals $100	6	10.00	100.00	**6000.00**	

GRAND TOTAL: 16062042.26

Total Estimated Unduplicated Participants: 1150

Factor D (Divide total by number of participants): 13966.99

Average Length of Stay on the Waiver: 315

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
Case Management Total:						**588294.00**
Case Management	1 unit = 1 month	1150	12.00	42.63	**588294.00**	
Personal Care Total:						**14570190.00**

GRAND TOTAL: 17354860.00

Total Estimated Unduplicated Participants: 1150

Factor D (Divide total by number of participants): 15091.00

Average Length of Stay on the Waiver: 315

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care	15-minute unit	890	3060.00	5.35	14570190.00	
Financial Management Services Total:						1636176.00
Financial Management Services	1 unit = 1 month	890	10.00	183.84	1636176.00	
Environmental Accessibility Adaptations Total:						28200.00
Environmental Accessibility Adaptations	1 unit equals $100	6	47.00	100.00	28200.00	
Specialized Medical Equipment and Supplies Total:						532000.00
Specialized Medical Supplies	1 unit equals $100	263	20.00	100.00	526000.00	
Specialized Medical Equipment	1 unit equals $100	6	10.00	100.00	6000.00	

GRAND TOTAL: 17354860.00

Total Estimated Unduplicated Participants: 1150

Factor D (Divide total by number of participants): 15091.00

Average Length of Stay on the Waiver: 315