

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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Significant changes being made with this renewal include; updating the waiver name from Medically Fragile Adult Waiver (MFAW) to Medically Complex Adult Waiver (MCAW) to better reflect the population served; adding, modifying, or deleting various performance measures; and revising the cadence of Level of Care (LOC) determinations from every six months to annually. The State also updated nomenclature throughout the application as the operating agency was restructured.

The estimated number of unduplicated participants that may be served under the waiver was set at 271 for year one. This is a decrease from the estimated number that may be served in the previous application. The estimated unduplicated number served in this renewal application was projected forward based on the current number of individuals served. There is no impact to current waiver participants.

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):

Medically Complex Adult Waiver

C. Type of Request: renewal

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

3 years 5 years

Original Base Waiver Number: MO.40190

Draft ID: MO.016.06.00

D. Type of Waiver (select only one):

Regular Waiver

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

07/01/26

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:

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 Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

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 RN Service Coordinators prior authorize waiver services. Services are delivered by providers that are enrolled with the Medicaid Audit and Compliance Unit (MMAC) as Medically Complex Adult Waiver (MCAW) providers. 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. Waiver services are accessed through referral to RN Service Coordinator for those participants who reach the age of 21, meet the criteria of the waiver and desire to remain in their homes. The RN Service Coordinator completes assessments for waiver eligibility and submits a request for review to DSDS Central Office nursing staff, who make the final determination of eligibility approval of available services.

Participants and/or responsible parties are provided with a list of service providers available in the area in which they live. Services are delivered through providers who have a participation agreement (contract) with DSS/MMAC. Participants and/or responsible parties may choose their provider and may change providers at any time. Services are prior authorized by the RN Service Coordinator and are subject to approval by the State Medicaid Agency, MHD. Providers are paid directly through the MHD MMIS system.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in 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. Statewide. Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):

No

Yes

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

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

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

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

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

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 inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of 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 renewal application, 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 Medically Complex Adult Waiver (MCAW) renewal application.

The public notice, along with a complete copy of the waiver renewal application, was published on the DSS website on November 20, 2025, 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 November 21, 2025.

Complete copies of the renewal application were also available by request from the DHSS/DSDS Central Office, on-line, 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, PO Box 6500, Jefferson City, MO 65102-6500, Attn: MO HealthNet Director, Email: AskMHD@dss.mo.gov. Per the notice, complete copies of the draft waiver renewal 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 PO Box 570, Jefferson City, MO 65102-0570.

On November 5, 2025, 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 renewal application. No comments were received in response.

A 30-day public comment period was provided from November 21, 2025, through end of business day December 21, 2025.

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

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

7. Contact Person(s)

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

Last Name:

Glenda

First Name:

Kremer

Title:

Assistant Deputy Director

Agency:

Missouri Department of Social Services, MO HealthNet Division

Address:

P.O. Box 6500

Address 2:

615 Howerton Court

City:

Jefferson City

State:

Missouri

Zip:

65102-6500

Phone:

(573) 751-9290

Ext:

TTY

Fax:

(573) 526-4651

E-mail:

Glenda.Kremer@dss.mo.gov

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

Last Name:

Highland

First Name:

Melanie

Title:

Division Director

Agency:

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

Address:

P.O. Box 570

Address 2:

912 Wildwood

City:

Jefferson City

State:

Missouri

Zip:

65102

Phone:

(573) 526-2636

Ext:

TTY

Fax:

(573) 751-8687

E-mail:

Mealnie.Highland@health.mo.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and

11/18/2025

certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

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

Ext:

TTY

Fax:**E-mail:****Attachments**

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

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

Reducing the unduplicated count of participants (Factor C).

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

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

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

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

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

(Complete item A-2-a).

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

Specify the division/unit name:

Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS)

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

MHD policy tracking

Responsible Party for data collection/generation(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 approved amount for services or, if less than approved amount, actual aggregate expenditures for services. Numerator= Aggregate approved amount for services or, if less than approved amount, actual aggregate expenditures for services.

Denominator= Total aggregate actual expenditures for services.

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation (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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

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

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Issues which require individual remediation may come to the attention of MO HealthNet (MHD) through review of the Division of Senior and Disability Services (DSDS) reports, as well as through day-to-day activities of the MHD, e.g., review/approval of provider agreements, utilization review and quality review processes, complaints from MHD participants related to waiver participation/operation by phone or letter, etc. MHD addresses individual problems related to delegated functions as they are discovered by contacting DSDS and advising them of the problem. A follow-up memo or email is sent from MHD to DSDS identifying the problem 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 addressed the problem identified by MHD. Written documentation is 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
	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)			
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Brain Injury			
		HIV/AIDS			
		Medically Fragile	21		
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability	21		
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

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

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

Not applicable. There is no maximum age limit

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	271
Year 2	306
Year 3	341
Year 4	376
Year 5	411

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 to allow all eligible participants to enroll in the waiver. In the event all slots are filled during a waiver year and a waitlist becomes necessary, the following protocol shall be used. Individuals are enrolled based upon the individual meeting the level of care and criteria specified in this waiver. In the event all slots are filled during a waiver year, individuals will be enrolled based upon the score of the level of care determination. If individuals have the same score, priority of available slots will be given to those with the greatest need. A high level of unit authorization is representative of individuals who have the greatest need in the state. If individuals have the same level of care score and authorization need, a date of referral will then be used.

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:

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

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time 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

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.

Must be a Registered Nurse (RN) who is licensed and in good standing in the State of Missouri.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and

the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The tool used to evaluate and reevaluate level of care is the Medically Complex Adult Waiver Level of Care Determination form. An assessment of the individual is conducted before the form is completed using the Medically Complex Adult Waiver Client Assessment form.

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

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, and undress, and complete daily grooming tasks. Dressing may also include specialized devices such as prosthetics, orthotics etc. (8) Rehabilitation: physician ordered rehabilitation therapy (speech, occupational, physical), points are based on frequency of services. (9) Treatments: physician ordered medical care or management that requires additional hands on assistance. (10) Medication Management: the ability to safely manage their medication regimen. (11) Meal Preparation: the ability to prepare a meal based on the capacity to complete the task. (12) Safety: identification of a safety risk associated with a visual impairment, unsteady gait, past institutionalization, past hospitalization, and age.

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

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

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

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

9 points: Mental conditions and symptoms currently exhibited, requires monitoring by a physician or licensed mental health professional, displays poor decision making and requires total supervision, total dependence on others or maximum assistance needed, therapies ordered more than once per day. 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. Upon meeting LOC, a person-centered approach is taken to determine the specific services available for authorization based on established service authorization guidelines.

To be eligible for the waiver, an individual must be assessed using the level of care criteria and have at least three of the following medical criteria and three functional limitations:

Medical Criteria:

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

Functional Criteria:

1. Self-care
2. Understanding and use of language
3. Learning
4. Mobility
5. Self direction
6. Capacity for independent living

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

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

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

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

The 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 for nursing facility admission and waiver services use the same scoring methodology described for each tool in Appendix B-6-d. The categories and scoring methodologies are established in the state nursing facility regulation. Since the nursing facility and waiver tools each utilize the same categories and scoring methodology for the LOC and are based on the same state regulations, the outcomes from the waiver 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 and reevaluations are conducted face-to-face, usually at the participant's residence. Sufficient information is obtained during this interview to complete the Level of Care (LOC) evaluation by means of a comprehensive assessment and completion of the MCAW Level of Care Determination form and Client Assessment form on an annual basis. The same process is used for initial evaluation and reevaluation. The RN Service Coordinator conducts quarterly contacts to evaluate ongoing medical necessity and the health and welfare of the participant.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

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

DSDS Central Office staff reviews the electronic case record to assure that each participant is assessed annually. Regional Office staff track and verify when assessments are coming due to ensure timely reevaluations.

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

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.

Original participant files are housed in the Regional Offices and accessible to DSDS Central Office staff for review through shared electronic drives. The files are stored in locked file cabinets, in a locked room for as long as the participant is receiving waiver services.

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 reasonable indication svcs may be needed in the future whose records show LOC determinations were done. N:# applicants for whom there is reasonable indication svcs may be needed in the future whose records show LOC determinations were done. D:Total # of applicants for whom there is reasonable

indication svs may be needed in the future whose records 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 =
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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: 	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:

#&% of participants for whom LOC processes & instruments were applied as described in the approved waiver to determine initial participant LOC. N = # of participants for whom LOC processes & instruments were applied as described in the approved waiver to determine initial participant LOC. D: Total number of participants with an initial LOC determination reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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.

When an error is discovered during a case record review or one is identified in a report, the DSDS Central Office staff reviews the error and works with the RN Service Coordinator who completed the assessment to appropriately address the error. The DSDS Central Office staff reviews the action taken by the RN Service Coordinator to correct the error. General methods of remediation may include: performing a LOC evaluation for those that were not done, re-training of staff, discussion during regional meetings and individual consults, and/or change in 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
	Continuously and Ongoing
	Other Specify:

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

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).

After initial evaluation and assessment, qualified individuals as specified in B-6-c explain to the potential waiver participant, and/or their responsible representative, the services available through the Medically Complex Adult Waiver (MCAW). Individuals can then make an informed choice between receiving services through an ICF/IID or the Home and Community-Based Services (state plan and/or waiver). The form that documents participant choice is the Client Choice Statement. Individuals are required to document their choice via a dated signature on the form, which is also signed and dated by the individual performing the assessment.

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

Original participant files are housed in the Regional Offices and accessible to the DSDS Central Office staff for review through shared electronic drives. The files are stored in locked file cabinets, in a locked room for as long as the participant is receiving waiver services.

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 (LEP) 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		
Extended State Plan Service	Waiver Attendant Care		
Other Service	Private Duty Nursing		
Other Service	Specialized Medical Supplies		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Waiver Attendant Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Waiver Attendant Care is above and beyond the limitations for State Plan Personal Care . The scope and nature of these services do not differ from State Plan Personal Care services with the exception that Waiver Attendant Care can be provided outside the home.

Personal care services are medically-oriented, maintenance services to assist with the activities of daily living. The encouragement and instruction of participants in self-care may be a component of any other task(s) as described above; however, encouragement and instruction do not constitute a task in and of themselves. Personal care services must include the performance of direct hands-on assistance and cannot consist solely of oversight or supervision

The following activities constitute personal care services and shall be provided according to the plan of care:

1. Assistance with dietary needs, including meal preparation and cleanup, and assistance with eating/feeding;
2. Assisting with dressing and grooming, including helping with dressing and undressing, combing hair, and nail care;
3. Assisting with bathing and personal hygiene, including assisting with bathing, shampooing hair, oral hygiene and denture care, and shaving;
4. Assisting with toileting and continence, including assisting in going to the bathroom, and changing bed linen. This category may also include the changing of beds for persons with medically related limitations that prohibit the completion of this task;
5. Assisting with mobility and transfer, including assisting with transfer and ambulation when participants can at least partially bear own weight;
6. Assisting with medication, including assisting with the self-administration of medicine, applying nonprescription topical ointments or lotions; and
7. Medically related household tasks

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

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

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	Personal Care Providers

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Waiver Attendant Care

Provider Category:

Agency

Provider Type:

Personal Care Providers

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

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

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

1. Be at least eighteen (18) years of age;
2. Be able to read, write and follow directions; and
3. Shall not be family member of the participant. Family member is defined as spouse; parent; sibling; child by blood, adoption, or marriage (stepchild); grandparent; or grandchild.
4. If the personal care attendant is providing advanced personal care, the aide must meet the criteria above to provide basic personal care and must meet the following additional criteria:
 - a) Be an LPN or a certified nurse assistant;
 - b) Be a competency evaluated home health aide having completed both written demonstration portions of the test required by the Missouri Department of Health and Senior Services and 42 CFR 484.36; or

Have successfully completed personal care aid training.

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

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

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

Missouri Medicaid Audit & Compliance

Frequency of Verification:

Upon initial enrollment and during MMAC Provider Review Audits.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

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in statute.

Service Title:

Private Duty Nursing

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05010 private duty nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Private duty nursing (PDN) is the delivery of professional nursing services on an individual and continuous care basis in (at least a 4-hour continuous block of time), (in contrast to part-time or intermittent care), provided under the direction of the participant's physician, by a licensed nurse acting within the scope of the Missouri Nurse Practice Act according to an individualized plan of care signed by the ordering practitioner. PDN includes shift care by a registered nurse (RN) or licensed practical nurse (LPN).

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

448 units (112 hours) per week is the maximum amount of PDN services that may be authorized. Exceptions can be made on a short-term, case-by-case basis with approval of DSDS Central Office staff when there is documentation to support this need. More than 112 hours of PDN services per week may be authorized in unique circumstances such as post-hospitalization. PDN services are authorized as a total number of units per month, based on weekly hours, which are determined by the assessed medical needs of the participant. Participants or their responsible parties may schedule services through their providers to meet their needs throughout the week and must stay within the authorized number of monthly units.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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	Private Duty Nursing providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Private Duty Nursing providers

Provider Qualifications

License (specify):

State Home Health Agency 197.400-475RSMo

Certificate (specify):

Medicare Home Health Agency

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Missouri Medicaid Audit and Compliance

Frequency of Verification:

Upon initial enrollment and during MMAC Provider Review Audits.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14032 supplies

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Specialized medical supplies are as specified in the participant's plan of care, and exclude items which are not of direct medical benefit or remedial benefit to the individual. All items shall meet applicable standards of manufacture and design, and must be furnished by MO HealthNet enrolled Durable Medical Equipment providers.

Examples of typically-covered items under the waiver include but are not limited to briefs, under-pads, and gloves.

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

Specialized medical supplies are not a routine covered service for adults under the Medicaid State Plan. All supplies are prior authorized by DSDS.

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	Durable Medical Equipment companies

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

Service Type: Other Service

Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment companies

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

Medicare certification

Other Standard (specify):

Enrolled with MHD

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

Missouri Medicaid Audit & Compliance

Frequency of Verification:

At the time of enrollment; prior to payment of service

Appendix C: Participant Services**C-1: Summary of Services Covered (2 of 2)**

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

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

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under 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:

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

- 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):

Providers are required to perform criminal/background investigations on all staff prior to employment in positions involving contact with participants. No person is allowed to be employed to work or volunteer in any capacity who left or was discharged from employment with any other employer due to abuse or neglect to patients, residents, or participants and the dismissal or departure has not been reversed by any tribunal or agency.

Prior to allowing any person who has been hired or contracted through an employment agency as a full-time, part-time or temporary position to have contact with participants, the Medically Complex Adult Waiver (MCAW) provider shall ensure the following background investigations have been completed:

1. Request a criminal record review with the Missouri State Highway Patrol (MSHP) in accordance with requirements of Chapter 43, RSMo;
2. Make an inquiry to the Department of Health and Senior Services (DHSS) whether the person is listed on the Employee Disqualification List (EDL) as provided in section 192.2490, RSMo;

Criminal background check requests may be submitted directly to MSHP and EDL checks may be submitted directly to DHSS.

Providers may satisfy these requirements by conducting an investigation through DHSS' Family Care Safety Registry (FCSR). The FCSR helps to protect waiver eligible individuals by compiling and providing access to background information. The FCSR 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) Childcare facility licensing records maintained by the Missouri Department of Elementary and Secondary Education
- 7) Foster parent licensing records maintained by the Missouri Department of Social Services

Providers are required to complete an EDL screening and a criminal background review through the MSHP for all new applicants prior to employment in positions involving contact with participants. Providers are also required to complete checks of the EDL at least annually to determine whether any current employee, contractor or volunteer has been recently added to the list. If the provider finds that a current employee was added to the EDL, that employee will not be allowed to be employed as a caregiver.

Providers using the FCSR to conduct the EDL and criminal background review fulfill the background screening requirements, provided there is sufficient documentation showing the identity of the person who was screened, the date the screening was required and completed, and the outcome of the screening.

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.

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

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

No. The state does not conduct abuse registry screening.

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (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 (explained in C-2-a). No person is allowed to be employed to work or allowed to volunteer in any capacity in any MCAW program who left or was discharged from employment with any other employer due to abuse or neglect to patients, participants or clients and the dismissal or departure has not been reversed by any tribunal or agency. Each MCAW 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 MCAW provider is also required to complete checks of the EDL at least annually to determine whether any current employee, contractor or volunteer has been recently added to the list. If the provider finds that a current employee was added to the EDL, that employee will not be allowed to be employed as a caregiver. 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 providers to assure that background investigations are conducted as required by statute and regulation. Background screening requests are a normal part of any review when records are requested from providers. Compliance monitoring will be conducted during regular monitoring visits, post payment reviews and complaint investigations. Frequency of post payment reviews is detailed in C-2-a.

Participants will continue to be fully staffed to meet their needs in the event their service provider(s) are added to the abuse registry.

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 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.

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

Other policy.

Specify:

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

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

MHD enrolled Home Health, Private Duty Nursing and Personal Care Program providers are required to complete an addendum and submit it to MMAC, Provider Enrollment Unit. Enrollment timeframes vary and are dependent upon the volume of requests for enrollment being processed by MMAC Provider Enrollment. Typically, MMAC Provider Enrollment reviews the application within 10-14 days of receipt. If the application is incomplete, it will be denied and the provider has 30 days to submit corrections. Corrected applications are reviewed within 14-21 days of receipt.

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.

Performance Measure:

& % of new Home Health Agency (HHA) MCAW providers that are DHSS-licensed/Medicare-certified who met initial waiver provider requirements prior to serving waiver participants. N = # of new (HHA) MCAW providers that are DHSS-licensed/Medicare-certified who met initial waiver provider requirements prior to serving waiver participants. D = Total # of new HHA MCAW 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

& % of Home Health Agency (HHA) MCAW providers that are DHSS-licensed/Medicare-certified who continue to meet waiver provider requirements. N = # Home Health agency (HHA) MCAW providers that are DHSS-licensed/Medicare-certified who continue to meet waiver provider requirements. D = Total # of HHA MCAW providers.

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

If 'Other' is selected, specify:

MMAC Enrollment

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

Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

Number and percent of new non-licensed/non-certified MCAW providers who met initial waiver provider requirements. Numerator = Number of new non- licensed/non-certified MCAW providers who met initial waiver provider requirements.

Denominator = Total number of new non-licensed/non-certified MCAW providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMAC 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:	

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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of non-licensed/non-certified MCAW providers who continue to meet waiver provider requirements. Numerator = Number of non- licensed/non-certified MCAW providers who continue to meet waiver provider requirements. Denominator = Total number of non-licensed/non-certified MCAW 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	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 waiver providers with staff who have passed designated manager certification. Numerator = Number of waiver providers with staff who have passed designated manager certification. Denominator = Total number of waiver providers that are required to have staff who have passed designated manager certification.

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: 	
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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of new providers that submitted documentation that state and waiver training requirements were met. Numerator = Number of new providers that submitted documentation that state and waiver training requirements were met. Denominator = Total number of providers required to submit such documentation.

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

If 'Other' is selected, specify:

Missouri Medicaid Audit and Compliance, Provider Contracts Report

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

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
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):

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

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the 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 the MO HealthNet Division (MHD) and Department of Health and Senior Services (DHSS) when actions are taken against a provider. Remediation may include recoupment of provider payments or termination of provider enrollment. MMAC monitors the provider for compliance. Information is provided to MHD and DHSS regarding the problems identified, remediation actions required and changes made by the provider to come into compliance. This information is tracked and trended to ensure problems are corrected.

ii. Remediation Data Aggregation

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

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

All MCAW services are delivered in the participant's home. Participants make the choice to live in their own homes, not homes that are provider owned or leased, and not in an institution or institution-like setting, and are able to receive services in the comfort of their own homes without restrictions of access to the community; therefore, this setting is compliant with the HCBS Settings Rule criteria.

All participants authorized for HCBS shall have a reassessment completed within 365 days of the last level of care determination. For participants receiving a Medically Complex Adult Waiver service, DSDS or its designee shall perform face-to-face reassessments with the participant utilizing the Client Assessment form and Level of Care Determination form and the Client Choice Statement to establish continued eligibility of services and compliance with the HCBS Settings Rule. The Client Choice Statement allows for a participant to report a concern. All concerns reported are relayed to MMAC for provider review.

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.)*

DSDS staff will make an initial home visit to ensure the participant's residence is compliant with HCBS standards specifically noting none of the exclusionary settings are applicable at the time of the home visit prior to enrollment and annually thereafter. DSDS Staff reviews services and service delivery at the annual treatment plan meetings and discusses with participant during quarterly contacts. Participants are not restricted and have full access to the community. DSDS will ensure settings remain in compliance during annual home visits and quarterly contact with participants. MHD verifies the monitoring during quarterly quality meetings and yearly oversight reporting.

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:

Plan of Care

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

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. DSDS staff 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 Client 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 staff 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 Medically Complex Adult 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 (annually) with the participant, and anyone they choose. The participant is contacted to schedule an appointment at their convenience, in regard to time and location. This process allows the participant to have anyone they choose there during the care planning process. The care plan is updated when DSDS staff are contacted by the provider or participant when there has been a change in the participant's circumstances or needs.
- (b) A comprehensive assessment that supports service plan development including the needs, preferences, goals, risks, and health status of the participant.
- (c) The services available through the Medically Complex Adult 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. 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 waiver provider, and the participant 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. The Client Choice Statement documents the waiver participant's consent of the person-centered care plan. The participant consents by signing the Client Choice Statement. The participant or their representative direct and have the primary authority in the development of the care plan to ensure the participant's needs and preferences are met and to ensure services are delivered in the most integrated community setting.

- 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 Client Choice Statement in order to document what actions are taken to mitigate any risk problems. DSDS staff are 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 be in the home 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, a report is to be made to the DHSS 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 Client Choice Statement by the participant's signature. A copy of the statement documenting participant choice is maintained in the HCBS case record. A list of all qualified providers is available to the participant upon request, at reassessment, or anytime the participant requests 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):

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 complete a 100% 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 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 100% sampling review performed by DSDS, MHD also conducts their own review based upon 25 randomly-selected participants. The review by staff MHD ensures individuals receiving waived 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 MHD, the state Medicaid agency, 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:

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, quarterly 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 Client 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 100% 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 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

Number and % 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. D: Total number participants whose service plans were reviewed.

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

If 'Other' is selected, specify:

Case Record Reviews

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and % of participants whose service plans indicate all personal goals have been assessed and addressed. Numerator: Number of participants whose service plans indicate all 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 =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other	

	Specify: 	
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Data Aggregation and Analysis:

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

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 participant's 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 =
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:

- 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:

and % of surveyed respondents indicating they received services by type, scope, amount, frequency, & duration meeting the needs identified in their service plan.
Numerator = Number of surveyed respondents indicating they received services by type, scope, amount, frequency, & duration meeting the needs identified in their service plan. Denominator = Total number of surveyed respondents 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 =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	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 percentage of participants whose records include the participant signature that specifies choice was offered between/among waiver services and providers. Numerator = Number of participants whose records include the participant signature that specifies choice was offered between/among waiver services and providers. Denominator = Total number of participants whose records 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 =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

	Other Specify: 	

Data Aggregation and Analysis:

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

- 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.

DSDS addresses any issues related to the Plan of Care in their quarterly record reviews immediately with the RN Service Coordinator. 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. The RN Service Coordinator is required to take appropriate corrective action. Follow-up to ensure the problem was remediated is done by DSDS Central Office staff. Individual problems are included in the annual waiver report. 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.

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

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

Appendix E: Participant Direction of Services

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

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

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

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

During the assessment/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 calendar 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 provide contact information to request a hearing.

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

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 Expectation for In-Home Services form states "If you feel your rights have been violated or if you or your family have been abused, neglected, or exploited, contact: Elder Abuse or Neglect Hotline 1-800-392-0120." This document is reviewed 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) conducting 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 least 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.

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

- 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.

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:

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 service 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 Central Registry Unit 800# (this number is promoted on DHSS public information, brochure, posters and website), making a referral 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. 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.

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 through 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 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 and quarterly contacts are conducted by State staff. Provider 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 DHSS if abuse, neglect, or exploitation is suspected.

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

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

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

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of seclusion

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

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 and quarterly contacts are conducted by State staff. Provider 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 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:

& % of hotline investigations (HIs) for waiver participants with credible evidence of ANE &/or unexplained deaths referred to an investigative entity for follow up. N: # of HIs for waiver participants with credible evidence of ANE &/or unexplained deaths referred to an investigative entity for follow up. D: Total # of HIs for waiver participant 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:

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

Performance Measure:

& % of participants 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):

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:	

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Data Aggregation and Analysis:

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

Performance Measure:

& % of hotline investigations (HIs) regarding substantiated allegations of ANE for waiver pts that resulted in a referral/safety plan to prevent future occurrences. N: # of HIs regarding substantiated allegation of ANE for waiver pts that resulted in a referral/safety plan to prevent future occurrences. D: Total # of HIs regarding substantiated allegations of ANE for waiver pts.

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

If 'Other' is selected, specify:

Hotline Database

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	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 hotline reports for waiver participants that were resolved and closed within required time frames. Numerator = Number of hotline reports for waiver participants that were resolved and closed within required time frames.

Denominator = Total Number of hotline reports 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 =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

	Other Specify: 	
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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of reports regarding unexplained deaths of waiver participants reviewed and closed within required time frames. Numerator = Number of reports regarding unexplained deaths of waiver participants reviewed and closed within required time frames. Denominator = Total number of unexplained death reports of waiver participants reviewed.

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

If 'Other' is selected, specify:

Hotline Database

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of hotline reports for waiver participants resulting in an investigation that was initiated within required timeframes. Numerator = Number of hotline reports for waiver participants resulting in an investigation that was 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 =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

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Data Aggregation and Analysis:

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

Performance Measure:

& % of critical incidents included abuse, neglect and exploitation (ANE) and unexplained deaths of waiver participants that the necessary corrective actions were taken. Numerator = Number of critical incidents included (ANE) and unexplained deaths of waiver participants that the necessary corrective actions were taken. Denominator = Total number of such reports for waiver participants reviewed.

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

If 'Other' is selected, specify:

Hotline Database

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

& % of reported restrictive interventions, including restraints and seclusion (RIs), reviewed to determine state policies and procedures were followed when RIs were used. N: # of reported RIs to determine state policies and procedures were followed when RIs were used. D: Total # of RIs reported.

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 =
Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

	Other Specify: 	
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Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

Number and percent of participants whose service plans addresses their health needs.

Numerator = Number participants whose service plans addresses their health needs.

Denominator = Total number of participants whose service plans 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 =
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.

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 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:

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

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 Operation Staff and Department of Health and Senior Services (DHSS)/Division of Senior and Disability Services (DSDS) staff meet to discuss the Quality Improvement Strategy (QIS) described throughout the Medically Complex Adult Waiver?40190; Brain Injury Waiver-1406; AIDS Waiver?0197; Aged & Disabled Waiver?0026; Independent Living Waiver?0346; Adult Day Care Waiver?1021.

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

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

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

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

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

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

The Quality Improvement Strategy spans all Missouri HCBS DHSS waivers, but all 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 Adult Day Care Waiver (ADCW), Aged and Disabled Waiver (ADW), Brain Injury Waiver (BIW), Independent Living Waiver (ILW), Medically Complex Adult Waiver (MCAW) and Structured Family Caregiving Waiver (SFCW) are evaluated and updated no less than annually by MHD and DHSS. The process includes the review of performance measures, reports for performance measures and remediation activities resulting from discovery. Annually, MHD and 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 ADCW, ADW, BIW, ILW, MCAW, 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 and service documentation on each waiver participant, including the name of the participant, the participant's MHD identification number, the names of the individual attendants who delivered the service, the date that the service was rendered, and the units of service provided. Providers are not required to have independent audits performed. Services provided through MCAW must be prior authorized by state staff; prior authorizations are based on the agreed-upon services established during the service planning process.

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

MMAC conducts periodic compliance audits in which the documentation of services provided is reviewed to ensure that services billed to MHD were provided and documented as required per state regulation. The selection of participants is determined by what providers are selected to be audited during the audit period timeframe.

Determination of the sample size of participants can be based on several different factors such as data analytics, targeted on certain procedure code(s), targeted issue such as overlap of other services, or specific to certain participants or discrepancies found at the time referrals or complaints are received. During a routine audit, participant sample is based on size of the provider. Frequency of reviews are dependent on data analysis, types and number of referrals, and bandwidth of staff available to review.

It is MMAC's intent to review waiver providers on a rotating basis, every three to five years. A provider with a history of problematic billing or complaints may be "spot checked" regarding those focused areas, in addition to receiving regular periodic audits. Reviews may be performed on-site or as a desk audit. A desk audit entails requesting records by mail, encrypted email, or encrypted fax. Providers are generally given 10 business days to produce records for a desk audit. The provider may then mail, securely fax, or securely email the requested records. Other than the requested records being sent in by the provider, the desk audit process is the same as on-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 may receive a call and a fax up to 24 hours prior to an onsite audit. The fax may contain 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 the violations and sanctions. The provider has 30 days to appeal and 10 days to submit a plan of correction. In the event of an overpayment under \$1,000, providers have 45 days to submit payment to MMAC, if payment is not received within 45 days MMAC will take immediate action to recover the overpayment amount. For overpayments over \$1,000 providers must pay the first 60% within 45 days. Providers may work with MMAC within 14 days of the notice to set up a repayment plan for the remaining 40% of the overpayment. If the provider is found not to have any violations, the provider will receive a "No Finding Letter" stating that the provider did not have any violations.

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

MMAC's areas of focus and selection of providers for general audit reviews are based on ideas from the Office of Inspector General (OIG) work-plan, Centers for Medicare and Medicaid Services (CMS) guidance and publications, trends, complaints and referrals, continued areas of non-compliance, and other factors. MMAC has a clinical service, HCBS, behavioral health, and mental health service review groups.

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

Review results statistics are available upon request.

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

The State requires providers to retain documentation for six years. 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 for authorization of services, MHD, and the providers. The case records contain the service plan (the basis for the prior

authorization).

MCAW 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 medical notes. Verification of correct names, and the begin and end times, etc. are also reviewed. MMAC expects to see any and all other documentation to support the provider's billings, such as time sheets, physician order's, nurse visit reports, care plans, employee screenings, etc. Background screening is reviewed as part of MMAC's audits/reviews. MCAW providers are required to utilize the Family Care Safety Registry (FCSR) for their criminal background check and EDL screening. In addition, they are required to do an EDL check annually. MMAC ensures employees are properly registered or have properly disclosed, and that initial and periodic screenings are performed, and that Good Cause Waivers (GCW) are applied for and received as necessary. As necessary, employees can request a GCW from DHSS' Division of Regulation and Licensure (DRL). State Statutes requires regulated health care employers to obtain background screenings prior to hiring an employee; to include the FCSR. An individual with a certain type of criminal history finding identified in their background screening cannot be hired by these employers. An individual who has been disqualified from employment has the right to apply for a GCW, which, if granted, would not correct or remove the finding, but would remove the hiring restriction and allow the individual to be employed. Verification of screening is requested and reviewed to see if the employees have been screened and that the screening was done timely. The participant's current plan of care and progress notes are reviewed to verify that the plan is being followed and that notes are being maintained. MMAC also audits/reviews for licensure qualifications, training and orientation qualifications, and other program specific qualifications. MMAC personnel are also independently able to verify employees' registration and screening through the FCSR. However, MMAC expects the providers to have access to paper copies of participants' care plans and expects the providers to have documentation of employee registration and screening (and application and granting of a GCW, if necessary.)

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

MMAC then reviews its State Regulation pertaining to sanctions (13 CSR 70-3.030) to determine the appropriate sanction. Providers may have the improperly paid money recouped or they may face more serious sanctions such as suspension or termination. Providers may face less serious sanctions in situations where the money was properly paid but there were minor findings such as inadequate documentation.

During an audit, MMAC checks employees who has or have had contact with participants who is part of the audit. MMAC also reviews the training and orientation documents during and audit.

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

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 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: 	
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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of providers with supporting documentation of services rendered for claims billed by provider. Numerator = Number providers with supporting documentation of services rendered for claims billed by 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 = plus/minus of 5% and a confident level of 90%
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):

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 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):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

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

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

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

ii. Remediation Data Aggregation

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

Responsible Party(check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	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 reimbursement rates are determined by DHSS, subject to budget appropriations, and approved by MHD. The reimbursement rate is a statewide rate; it does not vary by provider. The current reimbursement rate can be found on MO HealthNet's website at <https://mydss.mo.gov/mhd/fee-schedules-rate-lists>. Information regarding the payment rate is available upon request, through the MHD Constituent Services Unit or online at the MHD website. Requests may be made in writing to the MHD or DHSS, by e-mail to ASK MHD, or by phone call to the MHD Constituent Services Unit. To inform the fee schedule rates, the State's actuary conducts a formal rate study that considers the following key cost components:

Staff wages

Employee benefits and other employee-related expenses

Productivity

Other service-related expenses (e.g., supplies, facility square footage, transportation integral to the service)

Administrative expenses

To model the cost components, various market data sources are reviewed such as Bureau of Labor Statistics (BLS), Internal Revenue Service (IRS), Missouri-specific wages, and provider data and input. Historical market data is projected forward to a future rate effective period using an inflation adjustment based on BLS data. The market assumptions for each cost component are factored together to develop a unit rate. The State re-examines rates at least once every five years (formal rate study report completed in 2020; second one completed in early 2025). Rate increases are determined by the State based on the outcomes of the rate studies and available budget appropriations. Individuals, providers, and other stakeholders have an opportunity to make public comments to DHSS, MHD, and elected officials on rates and methodology for rate setting during annual legislative hearings in preparation for the appropriation process and during the rate study process. Many of the Medicaid maximum allowable rates have been adjusted over the years for COLA funding appropriated by the General Assembly. Individual rates may be adjusted for market or programmatic changes.

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

For this waiver renewal, 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 Medically Complex Adult Waiver (MCAW) renewal application.

The public notice, along with a complete copy of the waiver application, was published on the DSS website on November 19, 2025, 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 November 21, 2025. Complete copies of the application were also available by request from the DHSS/DSDS Central Office, on-line, 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, PO Box 6500, Jefferson City, MO 65102-6500, Attn: MO HealthNet Director, Email: AskMHD@dss.mo.gov. Per the notice, complete copies of the draft waiver 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 PO Box 570, Jefferson City, MO 65102-0570.

On November 5, 2025, 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 renewal.

A 30-day public comment period was provided from November 21, 2025, through December 21, 2025.

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

All services provided under this Waiver Program are prior authorized by the RN Service Coordinators, subject to approval by the MO HealthNet Division (MHD). The prior authorization is forwarded to the MHD Fiscal Agent. Providers of services bill claims for services directly to the MO HealthNet Fiscal Agent for claims processing. All claims are processed through the Medicaid Management Information System. Claims are checked against services prior authorized. Only authorized services are paid. Payment is made directly to the provider of service.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

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

Certified Public Expenditures (CPE) of Local Government Agencies.

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

Appendix I: Financial Accountability

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

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

The DSDS staff determine participants' eligibility for waiver services and develop/finalize the service plan. Based upon the participant's approved service plan, services are then prior authorized. This information is then transferred to the Medicaid Management Information System (MMIS) for establishment of a prior authorization for approved services against which all claims for payment from providers are compared. The MMIS system also incorporates an edit function that ensures services are only reimbursed to the provider for dates of service on which the participant is Medicaid eligible. The Missouri Medicaid Audit and Compliance (MMAC) within the Department of Social Services conducts periodic compliance audits in which the documentation of services provided is reviewed to ensure that services billed to MHD were provided and documented as required per Regulation. MMAC may arrange to conduct some interviews with waiver participants during monitoring; discussion of whether services were actually delivered is held during these interviews. When investigating a complaint, MMAC staff will also be verifying that services are delivered as reported. Providers are required to have adequate documentation of service delivery prior to filing claims for reimbursement through MMIS.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

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

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

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

Appendix I: Financial Accountability

g. Additional Payment Arrangements

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

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

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

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

ii. Organized Health Care Delivery System. Select one:

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

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

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

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of 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 home and community-based appropriations belong to the Department of Health and Senior Services (DHSS). Claims are processed through the Missouri Medicaid Information Systems (MMIS) and adjudicated for payment. During the adjudication process, the Department of Social Services/Division of Finance and Administrative Services has been granted authority by DHSS, to issue warrants to draw down funds from the DHSS state appropriation. Providers are then paid directly by the MHD, twice a month.

Other State Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

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

Other Local Government Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

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

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

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

Appendix I: Financial Accountability

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

a. Services Furnished in Residential Settings. Select one:

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

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

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver****Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

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

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)****a. Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

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

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

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

--

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

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

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	187506.01	42318.14	229824.15	311646.00	17141.00	328787.00	98962.85
2	197167.24	44857.22	242024.46	320372.00	18033.00	338405.00	96380.54
3	207319.74	47548.66	254868.40	329342.00	18970.00	348312.00	93443.60
4	218120.51	50401.58	268522.09	338564.00	19957.00	358521.00	89998.91
5	229441.77	53425.67	282867.44	348044.00	20995.00	369039.00	86171.56

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	271		271
Year 2	306		306
Year 3	341		341
Year 4	376		376
Year 5	411		411

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 326 days. This was calculated by using historical data regarding the average length of stay from CMS-372 reports, years 2019-2023.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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

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

Factor D users and units were projected based on the 372 Report and historic data for previous WYs 1-4 (2020 through 2025).

During that time period, there was a 5.11% average annual decrease in costs, a 4.28% average annual increase in users and a 1.45% increase in the reimbursement rate. With this renewal, the State used the current reimbursement rate of \$8.14 for previous WY5 (2026) and trended forward using the 1.45% historical average increase. Using these average annual increases, the average cost per user was projected forward through renewal WY 5 (2031). The state used the 4.28% average annual increase of users to trend forward from previous WY 4 (2025) to WY 5 (2026) and for renewal WYs 1-5 (2027-2031). For the units the state used the market basket rate of FY25 2.5% to trend forward from previous WY 4(2025) to WY 5 (2026) and for renewal WYs 1-5 (2027- 2031).

Private Duty Nursing (PDN):

Factor D users and units were projected based on the 372 Report and historic data for previous WYs 1-5 (2020 through 2025).

During that time period, there was a 14.58% average annual increase in costs and a 13.3% increase in the reimbursement rate. An average annual increase in users of 35 for the renewal period WYs 1-5 was determined by looking at multiple factors, including: historic data, increases in participant enrollment, aging caretakers who were previously able to provide for skilled needs but are no longer physically able to do so, anticipated transitions into the program for the next several years, and consideration of the likelihood of outside referrals. For the reimbursement rate, the State chose to use the FY25 2.5% market basket rate for the reimbursement rate trend. Historical rates during the previous WYs 1-4(2020-2025) were increased at unprecedented levels due to the COVID-19 pandemic. The State anticipated the reimbursement rates would level out, therefore, chose to use the market basket rate rather than historic data. With this renewal , the State used the current reimbursement rate of \$15.20 for previous WY5(2026) and trended forward using the FY25 2.5% market basket rate. Using these average annual increases, the average cost per user was projected forward for renewal WYs 1-5 (2027- 2031).

Specialized Medical Supplies (SMS):

Projections are based on 372 Report data for previous WYs 1-4 (2020 through 2025). During that time period there was a 6.4%

average annual increase in costs, a 2.65% average annual increase in users, and a 3.67% average annual increase in dollars per participant. The average annual units were projected to be 12 per year (1 per month). The 3.67% average annual increase in dollars per participant was applied to the average cost per unit per participant in previous WY4 (2025) of \$148.35 to project forward the average cost per unit for renewal WYs 1-5 (2027-2031).

The source link used to obtain the market basket index rate: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html>.

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

Factor D' is projected based on the 372 Report data for previous WYs 1-3 (2022-2024).

During that time period there was a 6% average annual increase in costs. The average annual expenditures for factor D' were projected by increasing the WY 3 (2024) expenditures by 6% annually. Medicare Part D is not a factor in our determination of Factor D'.

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

Factor G is based on the cost for MO HealthNet participants receiving services to meet their complex medical needs in an ICF/IID for previous WYs 2017-2021 and previous WY's 1-3 (2022-2024). For previous WYs 1-3 (2022-2024), the per diem rate had an average annual increase of 2.8%. The projections for Factor G are derived starting with the previous WY 4 (2025 per diem rate of \$815.20, and trended forward with an annual increase of 2.8%, and then multiplied by the average length of stay on the waiver of 340 days.

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

Factor G' is based on the actual state plan services for participants in an ICF-IID during previous WY's 2017- 2021 and previous WY's 1- 3 (2022-2024). There was an increase of 5.2% per participant in state plan services. The average annual expenditures for factor G' were projected by increasing the previous WY 3 (2024) expenditures by average rate of growth of 5.2% annually based on historical 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	
Waiver Attendant Care	
Private Duty Nursing	
Specialized Medical Supplies	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Attendant Care Total:						256142.60
Waiver Attendant Care	1/4 hour	14	2215.00	8.26	256142.60	
Private Duty Nursing Total:						50205942.38
Private Duty Nursing	1/4 hour	271	11891.00	15.58	50205942.38	
Specialized Medical						352043.52
GRAND TOTAL: 50814128.50 Total Estimated Unduplicated Participants: 271 Factor D (Divide total by number of participants): 187506.01 Average Length of Stay on the Waiver: 326						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supplies Total:						
Specialized Medical Supplies	Item	184	12.00	159.44	352043.52	
GRAND TOTAL: 50814128.50 Total Estimated Unduplicated Participants: 271 Factor D (Divide total by number of participants): 187506.01 Average Length of Stay on the Waiver: 326						

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Attendant Care Total:						285339.00
Waiver Attendant Care	1/4 hour	15	2270.00	8.38	285339.00	
Private Duty Nursing Total:						59672959.02
Private Duty Nursing	1/4 hour	306	12211.00	15.97	59672959.02	
Specialized Medical Supplies Total:						374877.72
Specialized Medical Supplies	Item	189	12.00	165.29	374877.72	
GRAND TOTAL: 60333175.74 Total Estimated Unduplicated Participants: 306 Factor D (Divide total by number of participants): 197167.24 Average Length of Stay on the Waiver: 326						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Attendant Care Total:						296692.50
Waiver Attendant Care	1/4 hour	15	2327.00	8.50	296692.50	
Private Duty Nursing Total:						70000411.80
Private Duty Nursing	1/4 hour	341	12540.00	16.37	70000411.80	
Specialized Medical Supplies Total:						398926.08
Specialized Medical Supplies	Item	194	12.00	171.36	398926.08	
GRAND TOTAL: 70696030.38 Total Estimated Unduplicated Participants: 341 Factor D (Divide total by number of participants): 207319.74 Average Length of Stay on the Waiver: 326						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Attendant Care Total:						328939.20
Waiver Attendant Care	1/4 hour	16	2385.00	8.62	328939.20	
Private Duty Nursing Total:						81244598.56
Private Duty Nursing	1/4 hour	376	12877.00	16.78	81244598.56	
Specialized Medical Supplies Total:						439774.08
Specialized Medical Supplies	Item	199	12.00	184.16	439774.08	
GRAND TOTAL: 82013311.84 Total Estimated Unduplicated Participants: 376 Factor D (Divide total by number of participants): 218120.51 Average Length of Stay on the Waiver: 326						

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Attendant Care Total:						363693.75
Waiver Attendant Care	1/4 hour	17	2445.00	8.75	363693.75	
Private Duty Nursing Total:						93483100.80
Private Duty Nursing	1/4 hour	411	13224.00	17.20	93483100.80	
Specialized Medical Supplies Total:						453771.60
Specialized Medical Supplies	Item	205	12.00	184.46	453771.60	
GRAND TOTAL: 94300566.15 Total Estimated Unduplicated Participants: 411 Factor D (Divide total by number of participants): 229441.77 Average Length of Stay on the Waiver: 326						