Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Includes Changes Implemented through November 2014

Submitted by:

Submission Date:	

CMS Receipt Date *(CMS Use)*	

Deleted Language – Bold/Strikethrough
New Language – Bold/Italicized

Application for 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:

A new medical component is being added under the Personal Assistant service, called Medical Personal Assistant. Independent Living Skills Development has been changed to Day Habilitation with more specific criteria in the service definition to highlight fundamental skills necessary to reside in the community. Criteria for Day Habilitation one on one services has been included as a Medical or Behavior Exception. Community Integration has been moved from the umbrella of Independent Living Skills Development to a separate stand-alone service, and provides clarification on the activities and skills allowed in order to support community integration and independence. Home Skills Development service has been replaced with Individual Skill Development as a stand-alone service, and provides clarification on the activities and skills allowed in order to support community integration and independence. Applied Behavior Analysis replaces Behavior Analysis Service to reflect recently approved MO HealthNet services and procedure codes in state plan. Job Preparation was renamed to Prevocational services to match CMS definition. The language was strengthened to be aligned with HCBS Community Settings Rule and to better individualize the service. Community Employment was renamed to Supported Employment services to match CMS definition. The language was strengthened to be aligned with HCBS Community Settings Rule and to better individualize the service. Co-Worker Supports was renamed to Job Development as it was previously embedded within the Community Employment definition. The language was strengthened to be aligned with HCBS Community Settings Rule and to better individualize the service. Job Discovery was renamed to Career Planning to match CMS definition. The language was strengthened to be aligned with HCBS Community Setting Rule and to better individualize the service. Communication Skills Instruction service was remove since it has not been used and the service falls within the Community Specialist definition. The Host Home definition was renamed to Shared Living since Host Home is a component of Shared Living, along with Companion Services.

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The 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.

State:	
Effective Date	

1. Request Information

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

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

C. **Type of Request:** *(the system will automatically populate new, amendment, or 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**
X	**5 years**

☐	**New to replace waiver** Replacing Waiver Number:		
	Migration Waiver – this is an existing approved waiver Provide the information about the original waiver being migrated		
	Base Waiver Number:		
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)		

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

○	**Model Waiver**
X	**Regular Waiver**

E. **Proposed Effective Date:** 07/01/2016

Approved Effective Date *(CMS Use):*

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 under age 21 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**
X	**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 facility level of care:	

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

Select one:

✓	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

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

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

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
☐	**A program authorized under §1915(i) of the Act.**
☐	**A program authorized under §1915(j) of the Act.**
☐	**A program authorized under §1115 of the Act.** Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

X	**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.

Goal: Establish and maintain a community based system of care for individuals who have ***intellectual and developmental*** **~~mental retardation and developmental~~** disabilities that includes a comprehensive array of services that meets the individualized support needs of individuals in a community setting.

Objectives: 1) provide individuals choice between ICF/**~~MR~~** ***ID*** institutional care and comprehensive community based care in a cost effective manner; 2) maintain and improve a community based system of care that diverts individuals from institutional care; 3) maintain and improve community based care so it is comprehensive enough to support individuals who transition from institutions; and 4) provide individuals choice and flexibility within a community based system of care.

Participants in this waiver require the highest levels of care. Approximately 60% of the participants receive residential services. Others are living with their families but require substantial supports in order to continue doing so.

The waiver is administered by the Division of Developmental Disabilities (DD) through an interagency agreement with the Single State Medicaid Agency, Department of Social Services and Mo Healthnet. Division of DD has **~~11~~** ***6*** Regional Offices***, with 5 satellite offices (herein referred to as Regional Offices)*** that are the gatekeepers for the waiver. The **~~11~~** Regional Offices determine eligibility, provide case management, and other administrative functions including quality assurance, person centered planning, and operation of prior authorization and utilization review processes. Through **~~intergovernmental agreements~~** ***contracts administered by the Department of Mental Health***, **~~a few~~** SB-40 Boards (public entities) ***and other TCM entities*** also provide limited waiver administration functions (case management) in coordination with Regional Offices and oversight from the Division of DD. **~~The State Plan was amended to add not-for-profit agencies registered with Secretary of State and designed by the Division of DD as a fourth type of Targeted Case Management provider.~~**

Service delivery methods in this waiver include provider-managed (for all waiver services); and there is a self-directed option for personal assistant ***and*** community specialist**.** **~~, and support broker.~~**

Each waiver provider has a contract with the Division of DD. DD Regional Offices authorize services to the providers. Providers must bill through the Division of DD's prior authorization system. The Division of DD submits the qualified bills to the Medicaid ***cla***im processing fiscal agent. The Medicaid MMIS pays the providers directly for services provided.

State:	
Effective Date	

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New Language – Bold/Italicized

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)*:

X	**Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
O	**No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

○	**Not Applicable**
X	**No**
○	**Yes**

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

X	**No**
○	**Yes**

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §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 Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

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

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

The division hosted public meetings during the summer of ~~**2009**~~ ***2015*** ***s***oliciting input from self-advocates, family members, providers and other stakeholders regarding the waiver reapplication. These meetings were facilitated by ~~**Robin Cooper of the National Association of Directors of Developmental Disability Services**~~ ***division staff***. ***Ongoing*** workgroups with representation from providers, self-advocates and family members me***e***t ~~**at least quarterly during the late summer and fall of 2009**~~ to assist in the ***enhancements of the waiver service delivery system.*** ~~**development of service definitions**~~. ***A stakeholder meeting took place in early October to discuss proposed waiver renewal changes.*** ~~**A stakeholder meeting took place in late November to discuss proposed performance measures and draft services, facilitated by Valerie Bradley of the Human Services Research Institute and Robin Cooper.**~~ Drafts were posted on the division's website and public input sought.

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 as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

7. Contact Person(s)

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

Last Name:	Kremer				
First Name:	Glenda				
Title:	Assistant Deputy Director, Program Operations				
Agency:	MO HealthNet Division				
Address :	615 Howerton Court				
Address 2:	P.O. Box 6500				
City:	Jefferson City				
State:	Missouri				
Zip:	65102-6500				
Phone:	(573) 751-6962	**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:	Brenner				
First Name:	Angela				
Title:	Director of Federal Programs				
Agency:	Missouri Department of Mental Health, Division of Developmental Disabilities				
Address:	1706 East Elm				
Address 2:	P.O. Box 687				
City:	Jefferson City				
State:	Missouri				
Zip :	65101				
Phone:	(573) 526-1853	**Ext:**		☐	**TTY**
Fax:	(573) 751-9207				
E-mail:	Angela.Brenner@dmh.mo.gov				

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

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

Signature:

_____

State Medicaid Director or Designee

Submission Date:	

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

Last Name:	Parks				
First Name:	Joseph				
Title:	Director				
Agency:	MO HealthNet Division				
Address:	615 Howerton Court				
Address 2:	P.O. Box 6500				
City:	Jefferson City				
State:	Missouri				
Zip:	65102-6500				
Phone:		**Ext:**		☐	**TTY**
Fax:					
E-mail:					

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

State:	
Effective Date	

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

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

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

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

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

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

Missouri administers Home and Community Based Waivers through Department of Social Services, MO HealthNet Division (MHD), which is the single State Medicaid agency. The day-to-day operation of the waivers is through a formal cooperative agreement with the Missouri Department of Mental Health (DMH). The Department of Mental Health is the operational entity for the waiver.
The formal cooperative agreement outlines specific duties related to the administration, operation and oversight functions of the waiver. The Medicaid Agency has ultimate administrative authority and oversight responsibility for the waivers. All official correspondence including this transition plan, waiver submissions and waiver amendments are developed by, jointly developed, or reviewed by the Medicaid Agency prior to submission to the Centers for Medicare and Medicaid Services. Any changes to a waiver program must be approved by the State Medicaid Agency. Oversight meetings are held quarterly to discuss waiver functions. The CMS Final Rule, including the activities listed in the transition plan, will be discussed quarterly during the oversight meetings. In addition to the quarterly oversight meetings, staff meets when situations arise that warrant discussion between agencies.
This transition plan is specific to the Community Support Waiver (MO.0404) and is consistent with the statewide transition plan submitted to CMS on March 13, 2015. The transition plan has been jointly developed by the Department of Social Services/MO HealthNet Division and the Department of Mental Health.

Section 1: Assessment
Missouri (MO) proposes a multi-faceted approach to assessment. This will include the completion of a Settings Analysis, which will be a high-level assessment of settings within the state to identify general

categories (not specific providers or locations) that are likely to be in compliance; not in compliance; presumed to be Non-Home and Community-Based Waiver Services (HCBS Waiver) or those that are not yet, but could become compliant. Other avenues for assessment will include identifying HCBS Waiver settings during provider enrollment and re-enrollment; evaluating settings through the existing HCBS Waiver quality assurance on-site review process and the provider self-assessment process; and monitoring of survey results for member experiences. Assessment activities will be incorporated into current quality assurance processes to the extent possible.

Action Item: Initial Settings Provider Self- Assessment Survey
Description: Incorporated HCBS Waiver setting questions into an initial provider survey. DMH will validate all of the initial DMH provider survey results with individualized provider information and initial on-site assessments.
Proposed Start Date: 6/23/14
Proposed End Date: 9/10/14
Sources/Documents: 2014 Settings Provider Self-Assessment Survey

Action Item: Settings Analysis
Description: State Identified HCBS Waiver settings as they potentially conform to HCBS characteristics and ability to comply in the future. General settings are classified into the following categories: Yes - Settings fully compliant; Not Yet - settings that will comply with changes; Not Yet - setting is presumed non-HCBS compliant but evidence may be presented for heightened scrutiny review; and No - setting does not comply. The Missouri HCBS Waiver Settings Analysis is being submitted as one component of the transition plan.
Proposed Start Date: 9/23/14
Proposed End Date: 2/02/15
Sources/Documents: Missouri Modified "Template for State Setting Analysis" herein referred to as Missouri HCBS Settings Analysis

Action Item: Geographic Information System (GIS) Evaluation of HCBS Service Settings and Addresses
Description: State: Use GIS to analyze locations of individuals' service settings and addresses to identify potential areas with high concentration of settings that are subject to heightened scrutiny.
Proposed Start Date: 12/16/14
Proposed End Date: 3/30/15
Sources/Documents: Addresses on MMIS Provider File - Provider Types 85, 26, 28, and 29, 58, 62, 94); Addresses on MMIS Participant File for individuals in 1915c waivers; The DMH will utilize the participant and provider agency addresses from current Licensure and Certification LCARS database.

Action Item: Initial Settings Assessment Tool Development
Description: State: Develop an initial settings assessment tool to be used by designated State staff for on-site reviews; Formal training on administering the tool prior to conducting on-site reviews.
Proposed Start Date: 2/01/14
Proposed End Date: 12/15/14
Sources/Documents: Final HCBS Regulations; Missouri Modified "Exploratory Questions to Assist States in Assessment of Residential Settings" herein referred to as Missouri Exploratory Questions for Assessment of HCBS Residential Settings; Missouri Modified "Settings That Isolate" herein referred to as Missouri - Settings with the Potential Effect of Isolating Individuals Receiving HCBS Waiver from the broader community; Initial Settings Assessment Tool; Training.

Action Item: Systemic Initial On-site Assessment

Description: State: Identify service settings that have the characteristics of HCBS Waivers or the qualities of an institution. Each service setting assessment will not exceed six months in duration. As assessments are completed for individuals served, summary of findings (including requirements for remediation) will be distributed to the individuals and service providers within 45 calendar days of the completed on-site assessment. A statistically valid sample size of settings (based on 95% confidence level) will be utilized for assessment. This sample will include information from the "Sources/Documents" Column. Settings found to need state consideration of a state request to CMS for Heightened Scrutiny will be given priority of review by DMH.
Proposed Start Date: 12/16/14
Proposed End Date: 4/1/16
Sources/Documents: Provider Relations Heightened Scrutiny Settings Analysis; 2014 Settings Provider Self-Assessment Survey; On-site assessment tool; GIS mapping; RAO Soft program for statistically valid sample size.

Action Item: Provider Enrollment Processes
Description: State will operationalize mechanisms to incorporate assessment of settings into existing processes for provider pre-enrollment screening, provider credentialing, and provider certification by the MO Department of Mental Health (DMH)
Proposed Start Date: 11/14/14
Proposed End Date: 3/2/15
Sources/Documents: Operational Procedures; Provider Pre-Enrollment Screening Assessment Tool; HCBS Certification Review Tools.

Action Item: On-going On-site assessment
Description: State will incorporate reviews of settings into existing quality integrated functions. As assessments are completed for individuals served, summaries of findings (including requirements for remediation) will be distributed to the individuals and service providers within 45 calendar days.
Proposed Start Date: 4/2/16
Proposed End Date: 4/02/17 and on an Annual basis thereafter
Sources/Documents: Provider Relations Reviews; Quality Enhancement Reviews to include National Core Indicators Surveys; TCM Technical Assistance Coordinator Reviews; Service Monitoring by Support Coordinators; Licensure and Certification Reviews; CIMOR EMT Contacts Process that includes anonymous input from individuals served and their advocates

Action Item: Enrolled HCBS Waiver settings providers self-assessment development
Description: Develop the Provider Self-Assessment to identify HCBS sites and to gather additional information from providers to assess sites of service that have characteristics of HCBS or the qualities of an institution. Providers will be required to submit the self-assessment annually.
Proposed Start Date: 10/1/14
Proposed End Date: 2/01/15 and annually thereafter
Sources/Documents: 2014 Settings Provider Self-Assessment; Missouri Modified "Exploratory Questions to Assist States in Assessment of Residential Settings" herein referred to as Missouri Exploratory Questions for Assessment of HCBS Residential Settings; Missouri Modified "Settings That Isolate" herein referred to as Missouri - Settings with the Potential Effect of Isolating Individuals Receiving HCBS Waiver from the broader community.

Action Item: Enrolled HCBS Waiver settings providers self-assessment distribution
Description: The self-assessment will be released to providers on January 1 and due to the State by April 1, with results compiled by May 15. Results will be shared with the public.

Proposed Start Date: 1/1/16
Proposed End Date: 05/15/16 and annually thereafter
Sources/Documents: Missouri Modified "Exploratory Questions to Assist States in Assessment of Residential Settings" herein referred to as Missouri Exploratory Questions for Assessment of HCBS Residential Settings; Missouri Modified "Settings That Isolate" herein referred to as Missouri - Settings with the Potential Effect of Isolating Individuals Receiving HCBS Waiver from the broader community.

Action Item: Enrolled HCBS Waiver settings -Missouri Exploratory Questions distribution
Description: Release the "Missouri Exploratory Questions for Assessment of HCBS Waiver Settings" document to assist providers in identifying if services are integrated in and have access to supports in the community, including opportunities to seek employment, work in competitive integrated settings, engage in community life, and control personal resources when completing the provider self-assessment.
Proposed Start Date: 1/1/15
Proposed End Date: 1/1/15
Sources/Documents: Missouri Modified "Exploratory Questions to Assist States in Assessment of Residential Settings" herein referred to as Missouri Exploratory Questions for Assessment of HCBS Residential Settings; Missouri Modified "Settings That Isolate" herein referred to as Missouri - Settings with the Potential Effect of Isolating Individuals Receiving HCBS Waiver from the broader community

Action Item: Missouri HCBS Waiver Participant Survey Development
Description: Develop an on-line participant survey to collect individual experiences to determine if service settings are in compliance with HCBS Waiver settings rule. The survey will include identification of the service setting, so the state can utilize this information in a follow up to the setting. The survey will provide the option for anonymity or to include contact information if they would like the state to discuss with them. If the participant discloses contact information, the state will do an on-site assessment.
Proposed Start Date: 11/1/14
Proposed End Date: 12/31/14
Sources/Documents: Missouri HCBS Waiver Participant Survey

Action Item: Missouri HCBS Waiver Participant Survey
Description: The survey will be released annually January 1 through December 31 with results compiled and report issued by March 1st. Results will be shared with the public.
Proposed Start Date: 1/1/15
Proposed End Date: 12/31/15 and annually thereafter
Sources/Documents: Missouri HCBS Waiver Participant Survey

Action Item: Assessment Results Report
Description: State compiles and analyzes findings of assessments and surveys. Findings will be presented to CMS, Missouri leadership and stakeholders beginning with initial assessment and annually thereafter.
Proposed Start Date: 4/30/16
Proposed End Date: 6/1/16 and Annually Thereafter
Sources/Documents: Assessments and surveys

Section 2: Remediation Strategies
Missouri proposes a remediation process that will capitalize on existing HCBS Waiver quality assurance processes including provider identification of remediation strategies for each identified issue, and on-

going review of remediation status and compliance. The state may also prescribe certain requirements to become compliant. Missouri will also provide guidance and technical assistance to providers to assist in the assessment and remediation process. Providers that fail to remediate non-compliant settings timely may be subject to sanctions in accordance with 13 CSR 70-3.030 and/or 9 CSR 45-5.060.

Action Item: Informational Letters
Description: Draft and finalize informational letters describing proposed transition, appropriate HCBS Waiver settings, deadlines for compliance, and technical assistance availability. This includes all of the letters that the state will be sharing with stakeholders throughout the process over the next few years.
Proposed Start Date: 6/23/14
Proposed End Date: 4/1/17
Sources/Documents: CMS Guidance; Proposed Transition Plan; CFR.

Action Item: Missouri Code of State Regulations (CSR) Review
Description: Review administrative rules to determine if revisions are needed to reflect federal regulations on HCBS settings.
Proposed Start Date: 10/1/14
Proposed End Date: 3/1/15
Sources/Documents: CMS Guidance; Proposed Transition Plan; CFR; Missouri 13 CSR 70; Missouri 9 CSR 45; Missouri 19 CSR 15; Missouri 19 CSR 30-90.

Action Item: Missouri Code of State Regulations (CSR) Filing
Description: File changes to administrative rules to as needed to reflect federal regulations on HCBS settings.
Proposed Start Date: 3/1/15
Proposed End Date: 10/1/16
Sources/Documents: CMS Guidance; Proposed Transition Plan; CFR; Missouri 13 CSR 70; Missouri 9 CSR 45; Missouri 19 CSR 15; Missouri 19 CSR 30-90.

Action Item: Provider Manual Revisions
Description: Revise HCBS provider manuals to incorporate HCBS final rule requirements. Manuals will be reviewed to determine if revisions needed to include HCBS Waivers setting thresholds and will prohibit new sites from being accepted or enrolled that have an institutional or isolating quality while presenting deadlines for enrolled providers to come into compliance. Rules will clarify expectations of member control of their environment and access to community.
Proposed Start Date: 1/1/15
Proposed End Date: 12/31/15
Sources/Documents: CMS Guidance; Proposed Transition Plan; CFR; Provider Manuals.

Action Item: Incorporate Education and HCBS Waiver Compliance Understanding into Provider Enrollment
Description: Make adjustments to ensure that HCBS Waiver settings are evaluated when appropriate. Process will include - When agencies enroll to provide HCBS Waiver services, they will be provided information on HCBS setting requirements and be required to certify that they have received, understand, and comply with these setting requirements. Thereafter, ongoing monitoring by division quality integrated functions (to include Provider Relations Reviews and Licensure and Certification Reviews) will be conducted to ensure compliance with the HCBS requirements.
Proposed Start Date: 11/16/14
Proposed End Date: 2/1/15 and annually thereafter

Sources/Documents: Missouri HCBS Waiver Settings Analysis; Missouri Exploratory Questions for Assessment of HCBS Residential Waiver Settings; Missouri - Settings with the Potential Effect of Isolating Individuals Receiving HCBS from the Broader Community; Provider Enrollment Tools; Provider Agreements/Contracts.

Action Item: Provider Update Meetings and Trainings
Description: Provide information to HCBS providers via webinars and during quarterly provider meetings (new information updates provided) - in each region. Webinars will be posted on the DMH website and providers informed by email when webinars have been posted.
Proposed Start Date: 6/23/14
Proposed End Date: 4/1/17 and quarterly thereafter
Sources/Documents: Missouri HCBS Waiver Settings Analysis; Missouri Exploratory Questions for Assessment of HCBS Residential Waiver Settings; Missouri - Settings with the Potential Effect of Isolating Individuals Receiving HCBS from the Broader Community; Provider Enrollment Tools; Provider Agreement.

Action Item: HCBS Waiver Settings Assessment Findings
Description: DMH will present individuals and service providers with the results of the assessment. The summary of findings (including requirements for remediation) will be distributed to the individuals and service providers within 45 calendar days of each on-site setting assessment.
Proposed Start Date: 12/16/14
Proposed End Date: 5/15/16 and annually thereafter
Sources/Documents: Assessment and surveys listed in this document.

Action Item: Provider Individual Remediation
Description: HCBS Waiver providers will submit a remediation plan within 45 calendar days from the issuance of the summary of assessment findings for any settings that require remediation. This plan will provide detail about the steps to be taken to remediate issues and the expected timelines for compliance. State review of remediation plans will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. The state will allow reasonable timeframes for large infrastructure changes with the condition that the Waiver providers receive department approval and provide timely progress reports on a regular basis.
Proposed Start Date: 3/2/15
Proposed End Date: 3/17/17
Sources/Documents: Missouri HCBS Settings Analysis; Missouri Exploratory Questions for Assessment of HCBS Residential Settings; Missouri – Waiver Settings with the Potential Effect of Isolating Individuals Receiving HCBS from the Broader Community.

Action Item: Periodic Provider Remediation Status Updates
Description: Providers will be required to submit periodic status updates on remediation progress.
Proposed Start Date: 3/2/15
Proposed End Date: 3/17/18
Sources/Documents: Missouri HCBS Settings Analysis; Missouri Exploratory Questions for Assessment of HCBS Residential Settings; Missouri – Waiver Settings with the Potential Effect of Isolating Individuals Receiving HCBS from the Broader Community.

Action Item: State Response to Provider Individual Remediation
Description: Accept the plan or may ask for changes to the plan. The state may pre-set remediation requirements for each organization's HCBS Waiver settings.

Proposed Start Date: 3/2/15
Proposed End Date: 3/17/18
Sources/Documents: Missouri HCBS Settings Analysis; Missouri Exploratory Questions for Assessment of HCBS Residential Settings; Missouri – Waiver Settings with the Potential Effect of Isolating Individuals Receiving HCBS from the Broader Community; Provider Remediation plans.

Action Item: Assessment Results Report – State level Remediation
Description: After findings from settings assessments and provider and individual surveys have been presented to CMS, Missouri leadership and stakeholders, the State will work with stakeholders to develop Remediation strategies for systems processes changes. Global systems enhancement might include revisions to existing integrated quality monitoring processes and enhanced HCBS provider and support coordination trainings
Proposed Start Date: 06/01/16
Proposed End Date: 03/17/17 and Annually thereafter
Sources/Documents: Assessments and Surveys

Action Item: Data Collection
Description: State will collect data from reviews, technical assistance, updates, etc. to track status of remediation efforts.
Proposed Start Date: 09/10/14
Proposed End Date: 04/02/17 and Annually thereafter
Sources/Documents: Electronic tools developed to capture data

Action Item: Departmental Management Report
Description: Data will be reported on a regular basis to Missouri departmental management and CMS
Proposed Start Date: 09/10/14
Proposed End Date: 04/02/17 and Annually thereafter
Sources/Documents:

Action Item: On-going Compliance Reviews
Description: State will conduct on-going reviews to establish and monitor levels of compliance reached by providers with non-HCBS settings following completion of their remediation schedule.
Proposed Start Date: 04/02/15
Proposed End Date: 04/02/16 and Annually thereafter
Sources/Documents: Provider Relations Reviews, Quality Enhancement Reviews to include National Core Indicators Survey, TCM Technical Assistance Coordinator Reviews, Service Monitoring by Support Coordinators, Licensure and Certification Reviews, CIMOR EMT Contacts Process that includes anonymous input from individuals served and their advocates

Action Item: Provider Sanctions
Description: State will sanction providers in accordance with 13 CSR 70-3.030 and/or 9 CSR 45-5.060 (add DHSS CSR) that have failed to meet remediation standards and failed to cooperate with the HCBS Settings Transition.
Proposed Start Date: 02/03/15
Proposed End Date: 3/16/15 and ongoing on an individual provider basis
Sources/Documents: Sanction Template Letter

Action Item: Individuals Transition to settings that align with HCBS requirements
Description: If relocation of individuals is necessary, the state will work with the individuals to ensure

that individuals are transitioned to settings meeting HCBS Setting requirements. Individuals will be given timely notice and due process, and will have a choice of alternative settings through a person-centered planning process. Transition of individuals will be comprehensively tracked to ensure successful placement and continuity of Waiver service.
Proposed Start Date: 03/16/15
Proposed End Date: 05/01/15 and ongoing on an individual basis
Sources/Documents: Sanction Template Letter, Notice of Decision (including appeal rights)
Data warehouse query of members affected and corresponding support coordinators, service workers, and care coordinators

Section 3: Public Comment
Missouri proposes to collect public comments on the transition plan in-person during two public forums. Missouri will also offer a conference line during the public forums. Missouri will provide an address for the public to mail in public comments as well. Through a series of stakeholder forums conducted throughout the state, Missouri will receive comments from our stakeholders. In addition to posting the transition plan and related materials on the Missouri MO HealthNet website, numerous stakeholders were contacted directly and provided with transition plan documents and information on the stakeholder forums. Stakeholders contacted include Missouri Association of County Developmental Disabilities Services (MACDDS), Missouri Association of Rehabilitation Facilities (MARF), Developmental Disabilities (DD) Council, People First, and The Arc.

Additionally for DHSS waivers: Adult Day Care Association, Leading Age.

Action Item: Announcement of Public Comment Period
Description: State released a Summary document, the Draft Transition Plan, and Draft Settings Analysis on the state website. A newspaper and an email blast will be released and the stakeholders will be contacted directly to inform them of the opportunity to provide public comment.
Proposed Start Date: 12/29/14
Proposed End Date: 03/07/15
Sources/Documents: Draft Transition Plan, Draft Settings Analysis, HCBS Settings Summary document, Newspaper release on 12/30/201, Email blast on 12/30/2014

Action Item: Public Comment Period and Meetings - Proposed Transition Plan
Description: State commenced stakeholder forums, shared proposed transition plan with public, collected comments, developed state responses to public comments, and incorporated appropriate suggestions into transition plan. The state will continue to document all iterations of the transition plan. The Response to Public Comments document is included in the Transition Plan.
Proposed Start Date: 12/29/14
Proposed End Date: 03/07/15
Sources/Documents: Draft Transition Plan, State Response to Public Comments Document

Action Item: Public Comment Retention
Description: State will safely store public comments and state responses for CMS and public consumption.
Proposed Start Date: 12/29/14
Proposed End Date: 03/17/19
Sources/Documents: Public Comment and State Response Document

Action Item: Posting of Transition Plan Iterations

Description: State will post each approved iteration of the transition plan to its website.
Proposed Start Date: 12/29/14
Proposed End Date: 03/17/15
Sources/Documents: Transition Plan, Rationale for Changes Made

Action Item: Assessment Findings Report
Description: State posts the findings of the on-site assessments and remedial strategies annually by August 1.
Proposed Start Date: 07/01/16
Proposed End Date: 08/01/16 and annually thereafter
Sources/Documents: Data compiled from documents, Remedial strategies included at aggregate level

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

State:	
Effective Date	

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)*	
X	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. Specify the division/unit name: Missouri Department of Mental Health, Division of Developmental Disabilities		
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b).*		

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.

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

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

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

In addition to Division of DD's ongoing record reviews throughout the year, MHD performs a statistically valid, statewide, annual record review, targeting problem areas identified through the reporting listed above. Problem areas are discussed with Division of DD who provides a corrective action plan to MHD outlining the steps being taken to address the problem. MHD continues to monitor for compliance to ensure that the action steps have been taken in a timely manner.

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

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) (s*elect one)*:

X	**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	Division of DD has a statewide contract for Fiscal Management Services that provide administrative functions to support individuals who self-direct services. This is the only contract entity that provides administrative services to waiver participants. The contractor***'s*** ~~**is a public accounting company with**~~ responsibilities ***are*** specifically related to processing payroll and reporting and paying related taxes and is not responsible for any functions listed in A-7.

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

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)*:

O	**Not applicable**
X	**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

X	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:* Local non-state entities (counties), referred to as Missouri County SB-40 Boards that are approved to provide Targeted Case Management for persons who have Developmental Disabilities, perform waiver operational and administrative functions at the local level with oversight from the operating agency, Division of Developmental Disabilities. There is an ~~**intergovernmental agreement**~~ ***contract*** between the Division of Developmental Disabilities and these entities that sets out the responsibilities and performance requirements. The ~~**agreement**~~ ***contract*** between the State operating agency and these entities is available through the MO HealthNet, the Medicaid agency. Participation in administrative/operational functions include: Participant waiver enrollment; waiver enrollment managed against approved limits; waiver expenditures managed against approved limits; level of care evaluation; review of participants' service plans; utilization management; quality assurance and quality improvement activities.
X	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*: Local non-governmental non-state entities, referred to as other not for profit entities that contract with the Division of Developmental Disabilities to provide Targeted Case Management services perform waiver operational and administrative functions at the local level with oversight from the operating agency, Division of Developmental Disabilities. There is a ~~**memorandum of understanding**~~ ***contract*** between the State and these entities that sets out the responsibilities and performance requirements for these entities. The ~~**memorandum of understanding**~~ ***contract*** between the State operating agency and these entities is available through the MO HealthNet, the Medicaid agency. Participation in administrative/operational functions include: Participant waiver enrollment; waiver enrollment managed against approved limits; waiver expenditures managed against approved limits; level of care evaluation; review of participants' service plans; utilization management; quality assurance and quality improvement activities.

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

The Operating Agency, Division of Developmental Disabilities, is responsible for assessing the performance of entities approved as Targeted Case Management providers for persons who have developmental disabilities and that also have responsibility for limited waiver administrative functions. In addition, the sample records of waiver participants that the MO HealthNet Division reviews, includes records of individuals for whom local SB-40 County Boards provide administrative functions.

Division of DD is also responsible for monitoring the fiscal management services contractor to ensure participants are promptly enrolled, workers are accurately paid, ***and*** associated payroll taxes for the employers are deposited. ~~**and the escrow account and program financial records are maintained according to generally accepted accounting standards."**~~

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

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

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

2) Division of DD Regional Office ~~**Consumer Relations**~~ ***Technical Assistance Coordinator*** Staff conducts quarterly reviews with TCM entities (both local public entities and local non-public entities) that have been delegated waiver administrative functions in the following areas:

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

b. Participant waiver enrollment managed against approved limits

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

d. Review of participant ~~service~~ ***support*** plans

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

f. Quality assurance and quality improvement activities

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

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

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	X	X	☐	X
Waiver enrollment managed against approved limits	X	X	☐	X
Waiver expenditures managed against approved levels	X	X	☐	X
Level of care evaluation	X	X	☐	X
Review of Participant service plans	X	X	☐	X
Prior authorization of waiver services	X	X	☐	☐

Utilization management	X	X	☐X	X
Qualified provider enrollment	X	X	☐	☐
Execution of Medicaid provider agreements	X	☐	☐	☐
Establishment of a statewide rate methodology	X	X	☐	☐
Rules, policies, procedures and information development governing the waiver program	X	X	☐	☐
Quality assurance and quality improvement activities	X	X	☐	X

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 waiver policies/procedures approved by the Medicaid agency prior to implementation. (Number of waiver policies/procedures reviewed prior to implementation/total number of waiver policies/procedures that were reviewed.)		
Data Source *(Select one) (Several options are listed in the on-line application):* Program Logs			
If 'Other' is selected, specify:			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	*+/- 5%*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*~~X~~ Quarterly*
☐ Other Specify:	*✓ Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of unduplicated participants exceeding the maximum enrollment limits. (Number of persons enrolled per Division of DD Quarterly Reports/maximum number of persons approved to be served)		
Data Source *(Select one) (Several options are listed in the on-line application):* 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)*

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

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*✓ Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of waiver service claims paid that ***did not*** exceed~~ed~~ the maximum allowable rate. (Number of paid waiver service claims by procedure code ***that did not*** exceed~~ing~~ the maximum reimbursement allowance/total number of paid waiver service claims by procedure code.)

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify: Report from MMIS of paid '85' DD waiver provider type claims

	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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*

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

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of MO HealthNet remediation actions requested of Division of DD, by type of remediation, that were properly resolved by Division of DD. (Total number of remediation actions properly resolved, by type of remediation/total number of remediation actions requested, by type of remediation.)		
Data Source *(Select one) (Several options are listed in the on-line application):* Program Logs			
If 'Other' is selected, specify:			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100%*

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

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of waiver enrollment complaints received by MO HealthNet that were resolved by Division of DD within timeline requested. (Number of enrollment complaints received directly by MO HealthNet that were resolved timely by Division of DD/total number of enrollment complaints received directly by MO HealthNet.)
Data Source *(Select one) (Several options are listed in the on-line application):* Program Logs	
If 'Other' is selected, specify:	

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

				Sample; Confidence Interval =
	☐ Other Specify:	*☐ Annually*		
		X Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	X Continuously and Ongoing
	☐ Other Specify:

~~***Performance Measure:***~~	~~**Number and percent of waiver service units authorized that were delivered based on billed units of service. (Number of waiver service units authorized by service procedure code/number of waiver services billed by service procedure code to MO HealthNet.)**~~
~~***Data Source (Select one) (Several options are listed in the on-line application):***~~	
~~***If 'Other' is selected, specify:*** **Division of DD authorization records and MMIS billed unit records.**~~	

	~~***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)***~~
	~~***X State Medicaid Agency***~~	~~***☐ Weekly***~~	~~***X 100% Review***~~
	~~***X Operating Agency***~~	~~***☐ Monthly***~~	~~***☐ Less than 100% Review***~~
	~~***☐ Sub-State Entity***~~	~~***X Quarterly***~~	~~***☐ Representative Sample; Confidence***~~

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

~~***Add another Data Source for this performance measure***~~

~~***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***~~
~~***X State Medicaid Agency***~~	~~☐ *Weekly*~~
~~***X Operating Agency***~~	~~☐ *Monthly*~~
~~☐ *Sub-State Entity*~~	~~***X Quarterly***~~
~~☐ *Other Specify:*~~	~~***X Annually***~~
	~~☐ *Continuously and Ongoing*~~
	~~☐ *Other Specify:*~~

Performance Measure:	Number and percent of untimely initial level of care determinations that were properly remediated by Division of DD. (Number of findings properly remediated by Division of DD in the sample/number of remediated findings reviewed in the MO HealthNet sample.)
Data Source *(Select one) (Several options are listed in the on-line application):* Program Logs	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval =*
	☐ Other	*X Annually*	*+/- 5%*

State:	
Effective Date	

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

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

~~Performance Measure:~~	**~~Number and percent of complaints received by DMH Office of Consumer Safety for Waiver Participants that were properly resolved. (Number of individual remediations that Division of DD properly resolved in the MO HealthNet sample/number of individual remediations reported by Division of DD that were in the MO HealthNet sample.)~~**
~~Data Source (Select one) (Several options are listed in the on-line application):~~	
~~If 'Other' is selected, specify:~~ **~~Reports to State Medicaid Agency on delegated Administrative Functions~~**	

	~~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)~~***
	~~X State Medicaid Agency~~	***~~☐ Weekly~~***	***~~☐ 100% Review~~***
	~~X Operating Agency~~	***~~☐ Monthly~~***	***~~X Less than 100% Review~~***
	~~☐ Sub-State Entity~~	***~~☐ Quarterly~~***	***~~X Representative Sample; Confidence Interval =~~***

State:	
Effective Date	

	~~☐ Other Specify:~~	~~X Annually~~		~~+/- 5%~~
		~~☐ Continuously and Ongoing~~		~~☐ Stratified: Describe Group:~~
		~~☐ Other Specify:~~		
				~~☐ Other Specify:~~

~~***Add another Data Source for this performance measure***~~

~~***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***~~
~~***X State Medicaid Agency***~~	~~***☐ Weekly***~~
~~***X Operating Agency***~~	~~***☐ Monthly***~~
~~***☐ Sub-State Entity***~~	~~***☐ Quarterly***~~
~~***☐ Other Specify:***~~	~~***X Annually***~~
	~~***☐ Continuously and Ongoing***~~
	~~***☐ Other Specify:***~~

Performance Measure:	Number and percent of service plans Division of DD properly remediated that had a finding that the plan was not adequate and appropriate to meet the needs in the plan. (Number of remediated service plans that were properly remediated in the sample/number of remediated service plans in the MO HealthNet sample.)

Data Source *(Select one) (Several options are listed in the on-line application):* Record Reviews, Off Site

If 'Other' is selected, specify:

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

	☐ *Other Specify:*	*X Annually*		*+/- 5%*
		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

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*
X State Medicaid Agency	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

~~***Performance Measure:***~~	~~**Number and percent of Division of DD findings of provider failure to initially meet or continue to maintain required licensure/certification that were properly remediated. (Number of providers that failed to initially meet or continue to maintain required licensure/certification and properly remediated divided by total number of ongoing providers seeking licensure/certification).**~~		
~~***Data Source (Select one) (Several options are listed in the on-line application):***~~ ~~**Record Reviews, Off Site**~~			
~~***If 'Other' is selected, specify:***~~			
	~~***Responsible Party for data collection/generation (check each that applies)***~~	~~***Frequency of data collection/generation: (check each that applies)***~~	~~***Sampling Approach (check each that applies)***~~
	~~***X State Medicaid Agency***~~	~~***☐ Weekly***~~	~~***☐ 100% Review***~~
	~~***X Operating Agency***~~	~~***☐ Monthly***~~	~~***X Less than 100% Review***~~
	~~***☐ Sub-State Entity***~~	~~***☐ Quarterly***~~	~~***X Representative Sample; Confidence***~~

				~~Interval =~~
	~~☐ Other Specify:~~	~~X Annually~~		~~+/- 5%~~
		~~☐ Continuously and Ongoing~~		~~☐ Stratified: Describe Group:~~
		~~☐ Other Specify:~~		
				~~☐ Other Specify:~~

~~Add another Data Source for this performance measure~~

~~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~~
~~X State Medicaid Agency~~	~~☐ Weekly~~
~~☐ Operating Agency~~	~~☐ Monthly~~
~~☐ Sub-State Entity~~	~~☐ Quarterly~~
~~☐ Other Specify:~~	~~X Annually~~
	~~☐ Continuously and Ongoing~~
	~~☐ Other Specify:~~

~~Performance Measure:~~	~~Number and percent of waiver services paid that did not go through the Division of DD prior authorization system. (Number of waiver services paid that were submitted through the Division of DD prior authorization system/number of waiver services paid.)~~
~~Data Source (Select one) (Several options are listed in the on-line application):~~ ~~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)~~
	~~X State Medicaid Agency~~	~~☐ Weekly~~	~~X 100% Review~~
	~~X Operating Agency~~	~~☐ Monthly~~	~~☐ Less than 100% Review~~
	~~☐ Sub-State Entity~~	~~☐ Quarterly~~	~~☐ Representative Sample; Confidence~~

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

~~***Add another Data Source for this performance measure***~~

~~***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***~~
~~***X State Medicaid Agency***~~	~~☐ *Weekly*~~
~~***X Operating Agency***~~	~~☐ *Monthly*~~
~~☐ *Sub-State Entity*~~	~~☐ *Quarterly*~~
~~☐ *Other Specify:*~~	~~*X Annually*~~
	~~☐ *Continuously and Ongoing*~~
	~~☐ *Other Specify:*~~

Performance Measure:	Amount and percent of variance between actual factor D + D' and G+G'. (Total of D+D'/Total of G+G') Measures cost effectiveness over ICF/MRs level of care.
Data Source *(Select one) (Several options are listed in the on-line application):* 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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other	*X Annually*	

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

Add another Data Source for this performance measure

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*
X State Medicaid Agency	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	Number and percent of untimely reevaluations of level of care determinations that were properly remediated by Division of DD. (Number of findings properly remediated by Division of DD in the sample/number of remediated findings reviewed in the MO HealthNet sample.)
Data Source *(Select one) (Several options are listed in the on-line application):* Record Reviews, Off Site	
If 'Other' is selected, specify:	

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

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

Add another Data Source for this performance measure

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*
X State Medicaid Agency	*☐ Weekly*
☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	Number and percent of redeterminations of level of care made by persons other than a qualified staff that were properly remediated by Division of DD. (Number of findings properly remediated by Division of DD in the sample/number of remediated findings reviewed in the MO HealthNet sample.)

Data Source *(Select one) (Several options are listed in the on-line application):* Record Reviews, Off Site

If 'Other' is selected, specify:

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

		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

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*
X State Medicaid Agency	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

~~***Performance Measure:***~~	~~**Number and percent of initial level of care determinations where the proper forms were not used that were properly remediated by Division of DD. (Number of findings properly remediated by Division of DD in the sample/number of remediated findings reviewed in the MO HealthNet sample.)**~~		
~~***Data Source (Select one) (Several options are listed in the on-line application):*** **Record Reviews, Off Site**~~			
~~***If 'Other' is selected, specify:***~~			
	~~***Responsible Party for data collection/generation (check each that applies)***~~	~~***Frequency of data collection/generation: (check each that applies)***~~	~~***Sampling Approach (check each that applies)***~~
	~~***X State Medicaid Agency***~~	~~***☐ Weekly***~~	~~***☐ 100% Review***~~
	~~***X Operating Agency***~~	~~***☐ Monthly***~~	~~***X Less than 100% Review***~~
	~~***☐ Sub-State Entity***~~	~~***☐ Quarterly***~~	~~***X Representative Sample; Confidence Interval =***~~
	~~***☐ Other Specify:***~~	~~***X Annually***~~	~~***+/- 5%***~~
		~~***☐ Continuously and Ongoing***~~	~~***☐ Stratified: Describe Group:***~~

		~~☐ Other Specify:~~		
				~~☐ Other Specify:~~

~~***Add another Data Source for this performance measure***~~

~~***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***~~
~~***X State Medicaid Agency***~~	~~***☐ Weekly***~~
~~***☐ Operating Agency***~~	~~***☐ Monthly***~~
~~***☐ Sub-State Entity***~~	~~***☐ Quarterly***~~
~~***☐ Other Specify:***~~	~~***X Annually***~~
	~~***☐ Continuously and Ongoing***~~
	~~***☐ Other Specify:***~~

Performance Measure:	Number and percent of redeterminations of level of care where the proper forms were not used that were properly remediated by Division of DD. (Number of findings properly remediated by Division of DD in the sample/number of remediated findings reviewed in the MO HealthNet sample.)
Data Source *(Select one) (Several options are listed in the on-line application):* Record Reviews, Off Site	
If 'Other' is selected, specify:	

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

		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

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*
X State Medicaid Agency	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

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. In addition, provide information on the methods used by the State to document these items.*

MO HealthNet has a Memorandum of Understanding with the Division of Developmental Disabilities (Division of DD) delegating administrative duties. MO HealthNet receives quarterly reports from the Division of DD in advance of a quarterly meeting with administrative and quality enhancement leadership team of Division of DD. Findings in the report are discussed and trends noted. MO HealthNet requests additional information and corrective action based on a review of data reported and discussed. Meeting minutes record discussions and follow-up/remediation required of Division of DD by MO HealthNet. MO HealthNet also has samples of individual remediations reported by the Division of DD to ensure findings were properly resolved around level of care, service plan, health and

safety, and qualified provider.

Performance measures related to policy and procedure review: A review of waiver policies and procedures will ensure that no Comprehensive Waiver policy/procedure is implemented by Division of DD prior to approval by MO HealthNet. These reviews will be documented in the MO HealthNet Waiver Review Log.

In addition, MO HealthNet will, through ongoing review of service plan, utilization review/quality review processes provided by Division of DD, and data obtained through the MMIS monitor to ensure compliance with all assurances and sub-assurances. If MO HealthNet discovers that a policy/procedure was implemented by Division of DD without MO HealthNet's approval, MO HealthNet will immediately notify Division of DD in writing that such policy or policy modification is not effective pending the review and approval of MO HealthNet. MO HealthNet will perform an expedited review of the applicable policy or policy modification, and will provide a written response regarding the disposition of the policy or policy modification. If revisions to the policy are needed, MO HealthNet will advise the Division of DD regarding required revisions, with subsequent review and approval by MO HealthNet prior to implementation of the policy or policy modification. If approved, the effective date of such policy or policy modification will be no earlier than the date of approval by MO HealthNet.

Remaining performance measures: Issues which require individual remediation may come to MO HealthNet's attention through quarterly review of the Division of DD Quality Management Reports, as well as through day-to-day activities of the MO HealthNet Division, e.g., review/approval of provider agreements, utilization review and Quality Review processes, complaints from MO HealthNet participants related to waiver participation/operation by phone or letter, etc. Remediation activities will be reported to MO HealthNet by the Division of DD as follow-up to these activities, and will also be aggregated in the Division of DD Quality Management Reports.

MO HealthNet requires that all individual issues are appropriately and timely remediated by Division of DD. If MO HealthNet discovers that any issue was not appropriately remediated, MO HealthNet will notify Division of DD and provide 10 days to identify an effective remediation strategy and 30 days to provide documentation to MO HealthNet that the strategy was implemented and was effective. All such issues will be included on the agenda for discussion at quarterly Quality Management Strategy Meetings. Inadequate remediation strategies identified by MO HealthNet, as well as alternative remediation strategies implemented by the Division of DD and dates of completion will be included in the MO HealthNet Waiver Review Log. The Waiver Review Log will identify MO HealthNet findings related to each performance measure, MO HealthNet and/or Division of DD remediation actions as appropriate, and timeframes required for remediation. On a quarterly basis, the MO HealthNet Waiver Review Log will include an analysis of data received from the Division of DD and data generated by MO HealthNet for the purpose of identifying the number and percentage of MO HealthNet and Division of DD findings appropriately remediated in accordance with specified timeframes.

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)*
	X State Medicaid Agency	*☐ Weekly*

	X Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*X Quarterly*
	☐ Other Specify:	*X 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.

X	**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

Appendix 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 a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
☐	**Aged or Disabled, or Both - General**				
	☐	Aged (age 65 and older)			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
X	**Intellectual Disability or Developmental Disability, or Both**				
	☐	Autism			☐
	X	Developmental Disability	0		X
	X	Mental Retardation	0		X
☐	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Participation in the DD Comprehensive Waiver requires otherwise eligible individuals be determined through the Division of DD's Utilization Review process to have needs that cannot be met in the Missouri 1915(c) DD Community Support Waiver #0404.01 which has an annual cap of $~~22~~***28***,000 in services and does not include residential services.

Through ~~the~~ person-centered planning**,** assessment of need is ongoing. When additional needs may arise that exceed the cost limits of a particular Division of DD waiver (e.g., Community Support Waiver ***or Partnership for Hope Waiver***), the planning team will support the individual to obtain additional waiver resources to meet the need. This may involve transitioning to a different waiver that offers these services.

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

X	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-2: Individual Cost Limit

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:

X	**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:**		
○	**Other:** *Specify:*		

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-3: Number of Individuals Served

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	~~**8275**~~***8782***
Year 2	~~**8500**~~***8882***
Year 3	~~**8500**~~***8982***
Year 4 (only appears if applicable based on Item 1-C)	~~**8610**~~***9082***
Year 5 (only appears if applicable based on Item 1-C)	~~**8782**~~***9182***

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.**
X	**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	~~**8175**~~***8682***
Year 2	~~**8400**~~***8782***
Year 3	~~**8400**~~***8882***
Year 4 (only appears if applicable based on Item 1-C)	~~**8510**~~***8982***
Year 5 (only appears if applicable based on Item 1-C)	~~**8682**~~***9082***

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.**		
X	**The State reserves capacity for the following purpose(s).** Purpose(s) the State reserves capacity for:		
	Table B-3-c		
		Purpose (provide a title or short description to use for lookup): Reserved Capacity Transition	**Purpose** (provide a title or short description to use for lookup): Reserved Capacity - Crisis
		Purpose (describe):	**Purpose** (describe):
		Reserved Capacity Transition is identified for persons who transition from a state operated ICF/~~MR~~ ***ID*** setting to home and community-based placements. Individuals who transition from state operated ICF/~~MR~~ ***ID*** settings to HCBS settings will not be transitioned to homes on the campuses of ICF/~~MRs~~***IDs***.	Reserve capacity for individuals in crisis is for individuals who are in emergency situations as defined by the Division of DD, 9 CSR 45-2.017 (E). Includes: 1) individuals in immediate need of life-sustaining services; 2) individuals needing immediate services to protect another person from imminent physical harm; 3) individuals transitioning from long-term institutional services; 4) individuals still requiring significant levels of service who are no longer eligible for another program or services (another waiver, etc.); 5) individuals in care and custody of Children's Division for whom there is a formal agreement in place with Division of DD; 6) individuals under age 18 requiring coordinated services through several agencies to avoid court action; or 7) individuals subject to ongoing or pending legal action requiring immediate delivery of services.
	Waiver Year	**Describe how the amount of reserved capacity was**	**Describe how the amount of reserved capacity was**

		determined:	**determined:**
		Reserve capacity for individuals transitioning from ICF/~~**MR**~~ ***ID*** settings based on data of persons entering the waiver for prior years.	Estimates are based on experience in prior years.
		Capacity Reserved	**Capacity Reserved**
	Year 1	50	200
	Year 2	50	200
	Year 3	75	200
	Year 4 (only if applicable based on Item 1-C)	75	200
	Year 5 (only if applicable based on Item 1-C)	75	200

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):*

X	**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:

X	**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:

Division of DD's Utilization Review (UR) Process, conducted by regional offices, prioritizes the needs of individuals in order to identify and serve individuals with the greatest needs first. The UR process is applied to all new ~~**service**~~ ***support*** plans and new/increased budgets developed by planning teams. The UR process is standardized for use at all regional offices. ~~**Service**~~ ***Support*** plans and budgets developed by Targeted Case Management Entities are also subject to this review process. The process rates priority of need and assigns points with a score of 12 representing individuals who have the greatest need in the State. Individuals with scores of 12 are served first statewide before individuals with scores of 11, 10, etc. are served. Should there be any change in the person's status

during this time, the Utilization Review Process will be updated in order to reflect the individual's current needs.

B-3: Number of Individuals Served - Attachment #1

Waiver Phase-In/Phase Out Schedule

Based on Waiver Proposed Effective Date:

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Phase-In/Phase-Out Time Schedule.** Complete the following table:

Beginning (base) number of Participants:

Phase-In or Phase-Out Schedule			
		Waiver Year:	
Month	**Base Number of Participants**	**Change in Number of Participants**	**Participant Limit**

c. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

d. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

○	§1634 State
○	SSI Criteria State
X	209(b) State

2. Miller Trust State.

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

○	No
X	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)			
X	Low income families with children as provided in §1931 of the Act		
☐	SSI recipients		
X	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
X	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:
~~X~~	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
X	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
~~☐~~ ***X***	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy in 209(b) States (42 CFR §435.330)		
☐	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
X	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*: The state elects to serve all other mandatory and optional groups included in the State plan, except for the Special home and community group under 42 CFR 435.217.		

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*	
X	**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 percentage:
☐	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%
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:

Appendix B-5: Post-Eligibility Treatment of Income

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.

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act. *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

○	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):	
	○	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

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

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional State supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○ %	**A percentage of the FBR, which is less than 300%** Specify the percentage:	
		○ $	**A dollar amount which is less than 300%.** Specify dollar amount:	
	○	%	A percentage of the Federal poverty level Specify percentage:	
	○	**Other standard included under the State Plan** Specify:		
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The following formula is used to determine the needs allowance:** Specify:			
○	Other Specify:			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	**Not Applicable**			
Specify the amount of the allowance (*select one*):				
○	**SSI standard**			
○	**Optional State supplement standard**			
○	**Medically needy income standard**			
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The amount is determined using the following formula:**			

State:	
Effective Date	

	Specify:

iii. <u>Allowance for the family</u> *(select one)*:

○	**Not Applicable *(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The State does not establish reasonable limits.**
○	**The State establishes the following reasonable limits** *Specify*:

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

c-1. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121 *Specify*:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	A percentage of the FBR, which is less than 300% Specify percentage:
		○	$	A dollar amount which is less than 300% of the FBR Specify dollar amount:
	○	%	A percentage of the Federal poverty level Specify percentage:	
	○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	Specify dollar amount: If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance *Specify*:			
○	Other (specify)			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	Not Applicable (see instructions)			
○	The following standard under 42 CFR §435.121 *Specify:*			
○	Optional State supplement standard			

○	Medically needy income standard		
○	The following dollar amount: Specify dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula: *Specify:*		

iii. <u>Allowance for the family</u> *(select one)*

○	Not applicable *(see instructions)*
○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula: *Specify:*
○	Other (specify):

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

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

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):

- ○ The following standard included under the State plan *(Select one):*
  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons** *(select one):*
    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ _____ % **A percentage of the FBR, which is less than 300%** Specify the percentage:
    - ○ $ _____ **A dollar amount which is less than 300%.** Specify dollar amount:
  - ○ _____ % **A percentage of the Federal poverty level** Specify percentage:
  - ○ **Other standard included under the State Plan** Specify:
- ○ **The following dollar amount** Specify dollar amount: $ _____ If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:** Specify:
- ○ **Other** Specify:

ii. <u>Allowance for the spouse only</u> (*select one*):

- ○ **Not Applicable**
- ○ **The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:** *Specify:*

Specify the amount of the allowance (*select one*):

○	**SSI standard**		
○	**Optional State supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. <u>Allowance for the family</u> *(select one)*:

○	**Not Applicable *(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The State does not establish reasonable limits.**
○	**The State establishes the following reasonable limits** *Specify*:

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

c-2. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(Select one):*			
○	**The following standard under 42 CFR §435.121:** *Specify:*			
○	**Optional State supplement standard**			
○	**Medically needy income standard**			
○	**The special income level for institutionalized persons** *(select one):*			
○	**300% of the SSI Federal Benefit Rate (FBR)**			
○	%	**A percentage of the FBR, which is less than 300%** Specify the percentage:		
○	$	**A dollar amount which is less than 300%.** Specify dollar amount:		
○	%	**A percentage of the Federal poverty level** Specify percentage:		
○	**Other standard included under the State Plan** Specify:			
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The following formula is used to determine the needs allowance:** Specify:			
○	**Other** *Specify:*			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	**Not Applicable**			
○	**The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**			

	Specify:

Specify the amount of the allowance (*select one*):

○	**The following standard under 42 CFR §435.121:** *Specify:*		
○	**Optional State supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. <u>Allowance for the family</u> (*select one*):

○	**Not Applicable *(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

○	**The State does not establish reasonable limits.**
○	**The State establishes the following reasonable limits** *Specify*:

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

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

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

i. Allowance for the personal needs of the waiver participant *(select one)*:			
○	**SSI Standard**		
○	**Optional State supplement standard**		
○	**Medically needy income standard**		
○	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
○	**The following formula is used to determine the needs allowance:** *Specify formula:*		
○	**Other** *Specify*:		
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. Select one:			
○	**Allowance is the same**		
○	**Allowance is different.** *Explanation of difference:*		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:			
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*			
○	**Not applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*		
○	**The State does not establish reasonable limits.**		

○	**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

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

e. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state – 2014 through 2018. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional State supplement standard**		
	○	**Medically needy income standard**		
	○	**The special income level for institutionalized persons** *(select one):*		
		○	**300% of the SSI Federal Benefit Rate (FBR)**	
		○ %	**A percentage of the FBR, which is less than 300%** Specify the percentage:	
		○ $	**A dollar amount which is less than 300%.** Specify dollar amount:	
	○	%	**A percentage of the Federal poverty level** Specify percentage:	
	○	**Other standard included under the State Plan** Specify:		
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The following formula is used to determine the needs allowance:** Specify:			
○	**Other** Specify:			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	**Not Applicable**			
○	**The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:** *Specify:*			
Specify the amount of the allowance (*select one*):				
○	**SSI standard**			

○	**Optional State supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. <u>Allowance for the family</u> *(select one)*:

○	**Not Applicable *(see instructions)***		
○	**AFDC need standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		
○	**Other** *Specify:*		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The State does not establish reasonable limits.**
○	**The State establishes the following reasonable limits** *Specify*:

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

f. Regular Post-Eligibility: 209(b) State – 2014 through 2018. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(Select one):*
  - ○ **The following standard under 42 CFR §435.121:** *Specify:*
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons** *(select one):*
    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ ____ % **A percentage of the FBR, which is less than 300%** Specify the percentage:
    - ○ $ ____ **A dollar amount which is less than 300%.** Specify dollar amount:
  - ○ ____ % **A percentage of the Federal poverty level** Specify percentage:
  - ○ **Other standard included under the State Plan** Specify:
- ○ **The following dollar amount** Specify dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:** Specify:
- ○ **Other** *Specify:*

ii. Allowance for the spouse only (*select one*):

- ○ **Not Applicable**
- ○ **The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:** *Specify:*

Specify the amount of the allowance (*select one*):	
○	**The following standard under 42 CFR §435.121:** *Specify:*
○	**Optional State supplement standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ ____ If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
iii. Allowance for the family (*select one*):	
○	**Not Applicable *(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** Specify dollar amount: $ ____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. Select one:	
○	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The State does not establish reasonable limits.**

○	**The State establishes the following reasonable limits** *Specify*:

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

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

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

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)*:			
○	**SSI Standard**		
○	**Optional State supplement standard**		
○	**Medically needy income standard**		
○	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
○	**The following formula is used to determine the needs allowance:** *Specify formula:*		
○	**Other** *Specify*:		
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. Select one:			
○	**Allowance is the same**		
○	**Allowance is different.** *Explanation of difference:*		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:			
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*			
○	**Not applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*		
○	**The State does not establish reasonable limits.**		

○	**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B-6: Evaluation / Reevaluation of Level of Care

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

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver 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**
	X	**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**
X	**By an entity under contract with the Medicaid agency.** *Specify the entity*:
	The State Plan was amended in 2009 to add a fourth type of TCM provider: not for profit agency registered with Secretary of State and designated by the Division of DD. The Division of DD Regional Office has final approval of all Level of Care evaluations.
○	**Other** *Specify*:

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

Initial evaluations are conducted by a qualified ***Support*** ~~**service**~~ coordinator employed by the Division of DD or Targeted Case Management Entities approved by Division of DD to provide targeted case management. All level of care determinations are approved by the Division of DD Regional Offices

and are subject to the approval of the State Medicaid Agency.

Qualifications of individuals performing level of care evaluations are specified in the Medicaid state plan for Targeted Case Management for persons with developmental disabilities approved by CMS September 11, 2009. This states that case managers employed by a qualified provider shall meet the minimum experience and training qualifications for a ~~Qualified~~ Developmental Disability Professional (~~Q~~DDP). The qualifications for a ~~Q~~DDP are the same as the minimum required for the position of Case Manager I with the Division of DD and require:

(1) One or more years of professional experience: (a) as a Registered Nurse; (b) in social work, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy, or a closely related area; or (c) in providing direct care to persons who have developmental disabilities; and

(2) A bachelor's degree from an accredited college or university with a minimum of 24 semester hours or 36 quarter hours of credit in one or a combination of human service field specialties. Additional experience as a Registered Nurse may substitute on a year-for-year basis for a maximum of two years of required education.

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 Division of Developmental Disabilities Waiver ICF/~~MR~~ ***ID*** Level of Care Determination Form is the instrument/tool used to determine level of care in this waiver just like the other DD waivers. An assessment of the individual is conducted before the form is completed using the Missouri Critical Adaptive Behaviors Inventory (MOCABI). This is a tool specific to Missouri that identifies functional limitations and needs. The Vineland Adaptive Behavior Scale or other age appropriate tools may be used for children when more appropriate.

The Division of Developmental Disabilities Waiver ICF/~~MR~~ ***ID*** Level of Care Determination must confirm and document the following:
1) The person has ***an intellectual disability*** ~~mental retardation~~ or a related condition;
2) The person has a need for a continuous active treatment program, including aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed toward the ***improvement of functional abilities, or are necessary to avoid*** ~~acquisition of~~ regression or loss of current optimal functioning status; and
3) there is a reasonable indication, based on observation and assessment of the person's physical, mental and environmental condition, that the only alternative services that can meet the individual's needs, if waiver services are not available, are services through an ICF/~~MR~~***ID***.

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 Division of DD.

Evaluations of level of care are completed by qualified ***support*** ~~service~~ coordinators employed by the Regional Office or an entity enrolled with MO HealthNet to provide targeted case management for individuals who have developmental disabilities ~~complete evaluations of level of care.~~ Regional Office administrative staff review the evaluation of level of care, the draft service plan, the priority of need recommendation and determine final eligibility for the waiver**.** ***All level of care redeterminations are approved by the Division of DD Regional Offices and are subject to the***

approval of the State Medicaid Agency.

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

○	**The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
X	**A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.** Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.
	The State uses the same tool to determine eligibility for ICF/~~**MR**~~***ID*** services and eligibility for nursing home services. Therefore, a different process/tool is used to determine eligibility for this waiver. The process/tool is analogous to the initial level of care assessment performed for admission to the ICF/~~**MR**~~ ***ID*** and nursing home programs, but is more appropriate to the assessment of persons who have developmental disabilities. The tool walks the evaluator through the process of determining: 1) if the individual has ***an intellectual disability*** ~~**mental retardation**~~ or a related condition based on identifying ***substantial functional limitations*** in 3 or more major life activities; 2) if the individual needs a continuous active treatment program, including aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed towards the acquisition of the behaviors necessary to function with as much self-determination and independence as possible; and the prevention **of deceleration** of regression or loss of current optimal functional status; and 3) if there is reasonable indication that without access to waiver services the only alternative services that will be available to meet the person's need are ICF/~~**MR**~~ ***ID*** services. The Division of Developmental Disabilities Waiver ICF/~~**MR**~~ ***ID*** Level of Care Determination Form is used to determine eligibility. The MOCABI or an age appropriate tool such as the Vineland is administered first to assess functioning level. The evaluator is also asked to report a summary/list of any other assessments and evaluations from the individual's record that may have been considered. Information from these assessments is used to complete the actual level of care determination form which results in a determination of eligibility.

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

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

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**
X	**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)*:

X	**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)*:

~~**Service**~~ *Support* Coordinators employed by the Division of DD regional offices or Targeted Case Management Entities are responsible for reevaluating each participant as part of the annual person centered planning process ~~**for**~~ ***regarding the in individual's*** continued need for an ICF/~~**MR**~~ ***ID*** level of care. Division of DD regional offices must approve ***claims of*** eligibility ***and associated*** ~~**decisions**~~ ***documentation*** ~~**that are**~~ made by Targeted Case Management ~~**Entity**~~ ***entity*** employees. All decisions are subject to approval of the Medicaid Agency.

The Division of DD Regional Office, in conjunction with the Targeted Case Management entity providing service coordination, is responsible for ensuring that reevaluations are completed annually. ~~**Ensuring this is done annually is the responsibility of the Division of DD Regional Office or the Targeted Case Management entity providing service coordination. Each agency must keep records to track the**~~ ***The*** number of annual re-determinations conducted of all current waiver participants ***and*** the number of individuals who continue to be found eligible and the number found to be ineligible ***are tracked electronically*** ~~**Each agency must forward a quarterly aggregate report summarizing this data to**~~ ***On a quarterly basis,*** the Quality Enhancement Leadership Team ***pulls data to*** ~~**and the team will**~~ assure compliance with this process as well as implement~~**ing**~~ any necessary corrective action. ***In addition, Regional Office staff as well as TCM entity staff have direct access to reports to monitor when Level of Care determinations and formal assessments are coming due. Support Coordinators and Support Coordinator Supervisors receive automated emails as a reminder of upcoming Level of Care determinations and formal assessments coming due.***

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

The DMH Consumer Information Management Outcomes and Reporting system (CIMOR) is a comprehensive data base that contains consumer demographics, service coordination information, waiver assignment, dates of evaluations, service plans, provider demographics, services by provider, waiver service authorizations and other information. CIMOR also has sophisticated reporting capacity, which is the process used to assure timely evaluations.

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

Evaluation and reevaluation records are located ***electronically*** ~~**in**~~ ***by*** the Division of DD. ~~**Regional Office serving the individual or the office of a Targeted Case Management entity approved by Division of DD to perform targeted case management.**~~

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.

i. Performance Measures

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

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

Performance Measure:	Number and percent of ~~**all new enrollees who have a**~~ completed assessment***s for all new enrollees*** indicating a need for ICF/~~**MR**~~***ID*** LOC prior to receiving services. (~~**New enrollees with assessments completed prior to receiving services**~~ ***Number of completed assessments of new enrollees indicating a need for ICF divided by ID LOC completed prior to receiving services divided by the number of*** all new enrollees)
Data Source *(Select one) (Several options are listed in the on-line application):* Analyzed collected data (including surveys, focus groups, interviews, etc.)	
If 'Other' is selected, specify:	

State:	
Effective Date	

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

Add another Data Source for this performance measure

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*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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

i. Performance Measures

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

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

Performance Measure:	~~**The**~~ Number and percent***age*** of ~~**waiver participants who received an**~~ annual level of care redeterminations***completed*** within ~~**12 months**~~***(365 days)*** of the~~**ir**~~ last annual LOC evaluation. (Number of ***completed annual level of care determinations that occurred within 365 days of the last annual*** LOC~~**redeterminations completed within 12 months(365 days) of last annual LOC determination**~~ *divided by the* ~~**÷**~~ ***Total number of level of care redeterminations required***)

Data Source *(Select one) (Several options are listed in the on-line application):* Analyzed collected data (including surveys, focus groups, interviews, etc.)

If 'Other' is selected, specify:

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

Add another Data Source for this performance measure

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*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other*	*X Annually*

State:	
Effective Date	

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

Add another Performance measure (button to prompt another performance measure)

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

i. Performance Measures

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

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

Performance Measure:	Number and percentage of LOC determinations ~~**for applicants**~~ completed by a qualified staff person. (***LOC determinations completed by a qualified staff person***~~**Number completed by a qualified staff person**~~ **divided** ***by*** ~~**÷**~~ ***Total number of completed LOC determinations***~~**All LOC**~~)
Data Source *(Select one) (Several options are listed in the on-line application):* 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*
	X Operating Agency	~~**X**~~ *Monthly*	~~**X**~~ *Less than 100% Review*
	X Sub-State Entity	☐ *Quarterly*	~~***X Representative Sample; Confidence Interval =***~~

State:	
Effective Date	

	☐ *Other Specify:*	☐ *Annually*		~~.95~~
		√ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

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*
~~X~~☐ *State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	Number and percentage of LOC determinations ~~that~~ us***ing*** ~~ed~~ instruments and processes described in the waiver application. (~~**Number of**~~ LOC ***determinations using instruments and processes*** ~~**completed using processes and instruments**~~ described in the waiver application divided by ***Total*** Number of ***completed*** LOC ***determinations***~~**completed**~~)
Data Source *(Select one) (Several options are listed in the on-line application):* 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*
	X Operating Agency	~~**X**~~ *Monthly*	~~**X Less than 100% Review**~~
	☐ *Sub-State Entity*	☐ *Quarterly*	~~**X Representative Sample; Confidence**~~

State:	
Effective Date	

				~~Interval =~~
	☐ *Other Specify:*	☐ *Annually*		~~.95~~
		√ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

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*
~~X~~☐ *State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	Number and percent of LOC determinations ~~**that were**~~ completed accurately (Number of LOC determinations completed accurately ÷ ***Total number of completed Level of Care determinations*** ~~**all LOC completed**~~).
Data Source *(Select one) (Several options are listed in the on-line application):* 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*
	X Operating Agency	~~***X***~~ *Monthly*	~~***X Less than 100% Review***~~
	☐ *Sub-State Entity*	☐ *Quarterly*	~~***X Representative Sample; Confidence Interval =***~~

State:	
Effective Date	

	☐ *Other Specify:*	☐ *Annually*		~~.95~~
		√ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

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*
~~X~~☐ *State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

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. In addition, provide information on the methods used by the State to document these items.*

When an error is discovered, a quality enhancement staff notifies the ***designated*** Regional ***Office staff***~~Technical Assistant Coordinator (TAC) Assistant Director of Habilitation~~ in writing within 10 days of the date of discovery. The ***designated Regional Office staff***~~local Assistant Director~~reviews the error, and works with ~~service~~ ***support*** coordination staff to correct the error. The ***designated Regional Office staff***~~TAC~~ ***enters the issue and remediation into the Division's electronic*** ~~Assistant Director will notify the quality enhancement staff in writing~~ within thirty (30) days describing how the error was corrected and any remedial staff training that was necessary. Methods of remediation include: performing a LOC for those that were not done, re-training of staff to perform a LOC accurately, establishing an individual tracking mechanism if one was not in place at the regional/county level. Remediation reported as: completed within 30 days, 31 to 60 days, more than 61 days and not completed.

ii Remediation Data Aggregation

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

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)*
	X State Medicaid Agency	*☐ Weekly*
	X Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*X Quarterly*
	☐ Other: Specify:	*X Annually*
		☐ Continuously and Ongoing
		☐ Other: Specify:

c. Timelines

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

X	**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.

State:	
Effective Date	

Appendix 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).

~~**Service**~~ ***Support*** Coordinator's employed by Division of DD Regional Offices and Targeted Case Management Entities approved to provide case management explain to individuals the choice between ICF/~~**MR**~~ ***ID*** institutional services and Home and Community Based services. Individuals, or a legally responsible party, are asked to make a choice between receiving services through the ICF/~~**MR**~~***ID*** Program or the HCBS Waiver Program. This is documented by the individual or a legal representative signing and dating a Waiver Choice Form. The ~~**service**~~ ***support*** coordinator also signs and dates the Waiver Choice form. Prior to authorization of waiver services the individual completes a form giving them the choice between ICF/~~**MR**~~ ***ID*** services and waiver services. If they choose the latter only then will waiver services begin. Forms are available upon request from the operating agency.

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

Signed and dated ~~**paper copies of**~~ Waiver Choice Forms are maintained in the individual's record at the regional office or the office of the Targeted Case Management entity that provides targeted case management.

Appendix B-8: Access to Services by Limited English Proficient Persons

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

The Office for Deaf and Multicultural Services is an agency-wide policy and program development office for the Department of Mental Health (DMH). This office is responsible for consultation and assistance to DMH facilities and providers delivering mental health services to eligible individuals who are Deaf, hard of hearing or from cultural minority people groups. Activities for systemic development include policy development, evidence based practices and program development informed by advisory input of DMH stakeholders.

All providers of services under contract with the Department of Mental Health are required to provide free language assistance per ~~**Title VI of the Civil Rights Act.**~~ ***Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.*** The state of Missouri has a statewide services contract that is available for providing over the phone verbal language interpretation (language line) and written language translation as well as sign language interpretation. Foreign language interpretation includes interpretation of all languages. If a client requests that a volunteer, friend, family member, etc. provide interpretation services, the state agency may utilize the volunteer, friend, family member, etc. to provide interpretation services, unless otherwise indicated by the state agency. In addition, because interpreting and alternative language services are also available in the Division of DD service catalog, Division of DD may contract with a qualified individual or agency to provide these services to an individual that has language interpretation needs. Interpreting capabilities shall include, but not be limited to, interpreting medical concepts/language, medical brochures, mental health therapy, mental health testing and evaluation, mental health topics in therapeutic situations, legal topics/concepts that focus on a client's incarcerations, capacity, etc., and highly technical concepts such as data processing terms. Those interpreters with specialized skills should be the preferred interpreters for providing services.

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

Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	✓	Personal Assistant
Adult Day Health	☐	
Habilitation	✓	Individualized Supported Living
Residential Habilitation	✓	Group Home
Day Habilitation	☐	
Prevocational Services	✓	~~**Job Preparation**~~
Supported Employment	✓	~~**Community Employment**~~
Education	☐	
Respite	✓	In Home Respite
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
✓	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Assistive Technology
b.	~~**Behavior Analysis Service**~~ **Applied Behavior Analysis**

c.	~~**Co-Worker Supports**~~ ***Job Development***
d.	~~**Communication Skills Instruction**~~
e.	Community Specialist
f.	Community Transition
g.	Counseling
h.	Crisis Intervention
i.	Environmental Accessibility Adaptations – Home/Vehicle Modification
j.	~~Host Home~~ Shared Living
k.	~~**Independent Living Skills Development**~~ ***Day Habilitation Services***
l.	***Community Integration***
m.	***Individualized Skill Development***
n.	~~Job Discovery~~ ***Career Planning***
o.	Occupational Therapy
p.	Out of Home Respite
q.	Person Centered Strategies Consultation
r.	Physical Therapy
s.	Professional Assessment and Monitoring
t.	Specialized Medical Equipment and Supplies (Adaptive Equipment)
u.	Speech Therapy
v.	Support Broker
w.	Transportation
Extended State Plan Services *(select one)*	
✓	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	
Supports for Participant Direction *(check each that applies))*	
☐	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
X	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in

	Appendix E.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	***X***	***Support Broker***
Financial Management Services	☐	
Other Supports for Participant Direction *(list each support by service title)*:		
a.		
b.		
c.		

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 Specification	
HCBS Taxonomy	
Category 1: ***08 Home Based Services***	Sub-Category 1: ***08030 Personal Care***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**: Personal Assistant**	

Personal Assistant Services include assistance with any activity of daily living (ADL) or instrumental activity of daily living (IADL). Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, care of adaptive equipment, meal preparation, feeding, and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation, and leisure activities. Assistance with IADLs includes accompaniment, cueing and minor problem-solving necessary to achieve increased independence, productivity and inclusion in the community. While ordinarily provided on a one-to-one basis, personal assistance may include assisting up to three (3) individuals at a time. With written approval from the Regional Office Director personal assistant services may be delivered to groups of four (4) to six (6) persons when it is determined the needs of each person in the group can be safely met.

Personal assistance may also include ~~**general supervision and protective oversight, which may be provided through**~~ ***the use of*** remote monitoring technology covered under the Assistive Technology service also in this waiver. The personal assistant may directly perform some activities and support the individual in learning how to perform others; the planning team determines the composition of the service and assures it does not duplicate, nor is duplicated by, any other service provided to the ***individual*** ~~**participant**~~.

For self-directed supports Team Collaboration allows the ~~**participant's**~~ ***individual's*** employees to participate in the service plan and to meet as a team to ensure consistency in its implementation. A team meeting also can be convened by the individual or their designated representative for the purposes of discussing specific needs of the individual, the individualized progress towards outcomes, and other related concerns. Team collaboration can be included in the individual budget up to 120 hours per plan year.

For agency-based personal assistant services, team collaboration is included in the unit rate.

Relatives as Providers

Personal assistant services shall not be provided by an individual's spouse, if the ~~**participant**~~ ***individual*** is a minor (under age 18) by a parent***, or by an participant's guardian or power of attorney***. Personal assistant services may otherwise be provided to a person by a member(s) of his or her family when the person is not opposed to the family member providing the service and the service to be provided does not primarily benefit

the family unit, is not a household task family members expect to share or do for one another when they live in the same household, and otherwise is above and beyond typical activities family members provide for another adult family member without a disability.

In case of a paid family member the service plan must reflect:
• The individual is not opposed to the family member providing services;
• The services to be provided are solely for the individual and not task household tasks expected to be shared with people living in family unit;
• The planning team determines the paid family member providing the service best meet the individual's needs;
• A family member will only be paid for the hours authorized in the service plan and at no time can these exceed 40 hours per week. Any support provided above this amount would be considered a natural support or the unpaid care that a family member would typically provide

Family is defined as: A family member is defined as a parent, step parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild.

Family members approved to provide personal assistant services may be employed by an agency or employed by the individual/guardian or designated representative using an approved fiscal management service provider. If the person employs his/her own workers using an approved fiscal management service provider, the family member serving as a paid personal assistant shall not also be the designated representative/common law employer.

Relation to State Plan Personal Care Services
Personal care services under the state plan differ in service definition, in limitations of amount and scope, and in provider type and requirements from personal assistant services under the waiver. When an individual's need for personal assistance is strictly related to ADLs and can be met through the MO HealthNet state plan personal care program administered by the Division of Senior and Disability Services (DSDS), he or she will not be eligible for personal assistant services under the waiver, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided.

DD Waiver personal assistant may be authorized when:
•State plan limits on number of units for personal care are reached and more ~~assitance~~***assistance*** with ADLs and/or IADLs is needed;
• Person requires personal assistance at locations outside of their residence;
• **The individual has behavioral or medical needs and they require a more highly trained personal assistant than is available under state plan.**
• When the personal assistant worker is related to the participant;
• When the participant or family is directing the service through the FMS contractor.

When waiver personal assistant is authorized to adults also eligible for state plan personal care, the ***Support***~~service~~ coordinator must consult and coordinate the waiver service plan with the DSDS service authorization system.

Personal care services are provided to children with disabilities according to the federal mandates of the Early Periodic Screening, Diagnosis and Treatment program. Personal Assistant needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Personal Assistant services through EPSDT for eligible persons under age 21 shall be provided and exhausted first before the waiver Personal Assistant service is provided. State plan personal care services for children are coordinated through the Bureau of Special Health Care Needs (BSHCN).

When waiver personal assistant is authorized for children also eligible for state plan personal care, the

***Support*~~service~~** coordinator must consult and coordinate with the BSHCN service authorization system.

Non-Duplication of Services
Personal Assistant services shall not duplicate other services. Personal assistance is not available to waiver recipients who reside in community residential facilities (Group Homes and Residential Care Centers). Persons who receive Individualized Supported Living (ISL) services shall not receive personal assistant services at their home but may receive this service outside the home - as long as not included in the ISL budget.

Personal Assistant Qualifications and Training
Training will cover, at a minimum:

a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Service Plan.
b. The rights and responsibilities of the employee and the individual, procedures for billing and payment, reporting and documentation requirements, procedures for arranging backup when needed, and who to contact within the Regional Office or Targeted Case Management entity.
c. Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.

d. Training in abuse/neglect, event reporting, and confidentiality.
e. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
f. CPR and first aid;
g***. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070***.~~**Medication Administration**~~**;**
h. ***Crisis intervention training***~~**Behavioral Intervention Training As needed**~~, due to challenging behavior by the Individual, the assistant will also be trained in behavioral intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
i. training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
j. Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual to be served and ~~**indentified**~~***identified*** by the team.

For SDS The planning team will specify the qualifications and training the personal assistant will need in order to carry out the service plan, where/by whom the assistant will be trained, and the source, method and degree of monitoring but not less than quarterly. To the extent they desire, the individual or designated representative will select the personal assistant and carry out training and supervision.
Individual/guardian or designated representative may exempt the following trainings if:
a. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
b. The personal assistant named above has adequate knowledge or experience in:
- CPR and first aid;
- Medication Administration;
- ***Crisis Intervention training*** ~~**Behavioral Intervention Training**~~ As needed, due to challenging behavior by the Individual, the assistant will also be trained in behavioral intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
- ~~**As needed,**~~ training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
- Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual to be served and ~~**indentified**~~ ***identified*** by the team.

Medical Personal Assistance
To assist in meeting the specialized medical needs for the individual as identified by the team and documented in the ISP, the following must have been met:
• The interdisciplinary team has identified and outlined the need to pursue more intensive support for medically related issues;
- ***The need must be documented by a physician or advanced practice nurse and maintained on file***

• Prior to approval of funding for medical personal assistance the ISP has gone through the local UR process to determine the above have been completed.
- ***Dependent upon the scope of service, a registered professional nurse may be required to provide oversight in accordance with the Missouri Nurse Practice Act.***

The medical personal assistance must adhere to the same requirements as outlined for the Individual Provider Employed by Individual or Family.

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

When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the individual's need for the service as an alternative to institutional care and the overall cost effectiveness of his or her service plan. Personal Assistant can occur in the person's home and/or community, including the work place. Personal Assistant shall not be provided concurrently with or as a substitute for facility-based day habilitation services.

Payment is on a 15 minute, fee for service basis, with different rates for individual and small group services, and, when needed, for enhanced staff qualifications.

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

Medical PA limitations
This service may not be provided by a family member or guardian unless the family/guardian has obtained the required and current certification and the individual receiving the care is over the age of 21.

Payment is on a 15 minute, fee for service basis, with different rates for individual and small group services, and, when needed, for enhanced staff qualifications. The same qualifications noted in personal assistance apply for the use of state plan services.

Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Employee of Consumer/Family		Individualized Supported Living Services	
	Relative Employed by Consumer/Family		Day Habilitation Services	

State:	
Effective Date	

	Independent Contractor	A Medicaid-enrolled provider of personal care services

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individualized Supported Living Services		DMH Certification for ISL; or CARF/CQL/Joint Commission accredited for ISL.	DMH Contract; The agency-based provider of personal assistance must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; and the planning team may specify additional qualifications and training necessary to carry out the service plan.
Day Habilitation Services		DMH Certification for day hab; or CARF/CQL/Joint commission accredited for day hab	DMH Contract; The agency-based provider of personal assistance must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; and the planning team may specify additional qualifications and training necessary to carry out the service plan.
A Medicaid-enrolled provider of personal care services.			DMH Contract; DHSS Medicaid Personal Care Enrollment; The agency-based provider of personal assistance must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; and the planning team may specify additional qualifications and training necessary to carry out the service plan.
Employee of Consumer/Family			Age 18; meets minimum training requirements; agreement with Division RO; agreement with individual/designated ***representative;*** ~~**representitive;**~~ Planning team will specify the qualifications and training the personal assistant will need in order to carry out the service plan; Supervision is provided by the consumer, family or a designated support broker in

			providing service in the home or community consistent with the service plan.
Relative Employed by Consumer/Family			Age 18; meets minimum training requirements; agreement with Division RO; agreement with individual/designative ~~**represenitive**~~ ***representative***; Shall not be the consumer's spouse; a parent of a minor child (under age 18); a legal guardian; nor the employer of record for the consumer. The individual shall not be opposed to the family member providing care. The planning team agrees the family member providing the personal assistant service will best meet the individual's needs. Family members employed by the consumer or designated representative are supervised by the consumer or a designated representative in providing service in the home or community consistent with the service plan. Family members employed by an agency are supervised by the agency.
Independent Contractor	Missouri State professional license such as RN or LPN,		DMH Contract; Shall not be the consumer's spouse; a parent of a minor child (under age 18); nor a legal guardian

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individualized Supported Living Services	Regional office staff	Prior to contract approval or renewal; as needed based on service monitoring concerns
Day Habilitation Services	Regional office staff	Prior to contract approval or renewal; as needed based on service monitoring concerns
A Medicaid-enrolled provider of personal care services.	Agency verifies qualifications of personal assistant; oversight by Regional office staff	Agency verifies upon hiring and as needed based on supervision; regional office monitors provider ~~**annually**~~ ***every three years.***

Employee of Consumer/Family	Family; Regional office has oversight	Prior to signed agreement with regional office and consumer/family; service review as needed based on service monitoring concerns; as consumer's needs change
Relative Employed by Consumer/Family	Regional office staff	Prior to signed agreement with regional office and consumer/ family; service review as needed based on service monitoring concerns; as consumer needs change
Independent Contractor	Regional office staff	Prior to signed contract; as needed based on service monitoring concerns and as consumer needs change

Service Specification	
HCBS Taxonomy	
Category 1: ***17 Other***	Sub-Category 1: ***17990 Other***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**: Individualized Supported Living**	

Individualized Supported Living (ISL) is characterized by creativity, flexibility, responsiveness and diversity. Individualized supported living enables people with disabilities to be fully integrated in communities. ISL services provide individualized supports, delivered in a personalized manner, to individuals who live in homes of their choice. Individuals receiving ISL supports may choose with whom and where they live, and the type of community activities in which they wish to be involved.

Individualized supported living reflects these principles:

- a) People live and receive needed supports in the household of their choice which might include their family home, an apartment, condominium, or house in settings typical of people without disabilities. The selected housing should represent an adequate standard of living common to other citizens, allowing for reasonable protection and safety**. *Provider owned or leased facilities where residential habilitation services are furnished must be compliant with the Americans with Disabilities Act.***

b) Personal preferences and desires of those served are respected. Personal autonomy and independence are promoted. Individuals receiving services lead the planning, operation, and evaluation of services. The participant's self-direction and control leading toward self-governance are maximized through services rendered.

c) Existing resources and natural supports, paid and unpaid, are maximized from the community at large.

d) Training focuses on acquiring functional, useful skills within the community. Services minimize the need for skill transfer by providing training in the environment in which the skills are required.

e) Services are "outcome" focused, addressing the quality of life being experienced in the present life style and not in the potential future implied by skill development/attainment.

f) Services are provided based on individual needs not predicated on inflexible restrictions of specific funding mechanisms.

g) Service goals are directed toward participation in the life of one's own community. As with any other citizen, this involves individual participation in civic activities and joining community organizations assuming those roles which are valued by the community.

If individuals choose to live with housemates, no more than four individuals receiving ISL services may share a residence. Individuals receiving ISL services and sharing a home with housemates shall each have a private bedroom. Couples sharing a home where one or both of the couple receives ISL services may share a bedroom if they so choose.

This service provides assistance and necessary support to achieve personal outcomes that enhance an individual's ability to live in and participate in their community. ISL services and supports are individually planned and budgeted for each person served. Services are designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Individualized supported living services may also include assistance with activities of daily living and assistance with instrumental activities of daily living, depending upon the needs of the individual. Services may include up to 24 hours of support including a combination of habilitation and/or personal support as specified in his/her Service Plan. Each resident in the home has free choice of provider and is not required to use the same ISL provider chosen by their housemates.

The residence (house or apartment) is a private dwelling, not a licensed facility and must be owned or leased by at least one of the individuals residing in the home and/or by someone designated by one of those individuals such as a family member or legal guardian.

ISL budgets include the following:
Direct Support, which includes:

Direct Support Staff
Professional management, responsible for:
•Staff training and supervision;
•Quality enhancement monitoring;
•Direct plan implementation for individuals as needed;
•Monitoring implementation of outcomes;
•Establishing information collection systems;
•Writing monthly reviews;
•Oversight/coordination of all the person's programs and services being received; and
•Coordinating the development of the individual service plan (scheduling, facilitation and summary document).
~~**Travel**~~
Back-up and safety net supports, which include
•Maintenance of a phone number which will be answered 24 hours and to assure a regular point of contact for the person supported;

•Provide a back-up plan should other supports fail to materialize as planned; and
•Assuring communication regarding changes in the person's life (health, behavior, employment, etc.), with those important to the individual, including, but not limited to: Family/guardians, educational staff, employer, day program, case manager, physicians, etc.
~~**Monthly Registered Nurse oversight**~~

Administrative costs

Transportation and Monthly Registered Nurse Oversight Services can be provided through an ISL provider, in conjunction with the ISL service, but are authorized separately and not included in the daily rate.

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

No payment is made for supports provided, directly or indirectly, by members of the individual's immediate family. Immediate family, for purposes of ISL services, includes parent, child, sibling, spouse or legal guardian.

Because the ISL service includes assistance with activities of daily living and assistance with instrumental activities of daily living, people who use ISL will not also receive state plan personal care.

Individuals who receive ISL services shall not receive waiver personal assistant services at their home but may receive this service outside the home as long as it is not included in the ISL budget. Individuals who receive ISL services may also receive ~~**Independent Living Skills Development**~~ ***Day Habilitation , Community Integration, Individualized Skill Development,*** Behavior Analysis, ~~**Community Employment**~~ ***Supported Employment,*** , Crisis Intervention, etc. and other waiver services that are identified as needs through the person centered planning process as long as there is no duplication with the ISL service and it is not included in the ISL budget.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Individualized Supported Living

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individualized Supported Living	9 CSR 40-1,2,4,6	9 CSR 45-5.010; CARF; CQL; or Joint Commission	DMH Contract; Staff qualifications are in DMH contract and are summarized as follows: Must be 18 years of age; have a high school diploma or its equivalent; training in preventing, detecting, and reporting of abuse and neglect prior to providing direct

			care; training in the implementation of each individual's service plan within one month of employment; training in positive behavior support curriculum approved by the Division of DD within 3 months of employment. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individualized Supported Living	Regional Office	Prior to contract approval or renewal; as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***02 Round the Clock Services***	Sub-Category 1: ***02011 Group Living, Residential Habilitation***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:** Group Home

Group home services provide care, supervision, and skills training in activities of daily living, home management and community integration. The services are provided to groups of recipients in group homes, residential care centers and semi-independent living situations (clustered apartment programs) licensed or certified by DMH. Licensure, certification and accreditation all meet the requirements of 45 CFR Part 1397 for board and care facilities. A unit of service is one day (24 hours).

Group homes are owned and operated by public or private agencies under contract with the DMH Division of Developmental Disabilities.

Group homes are paid a per-diem rate for each resident which covers:

- Staff ~~**intervention**~~ ***provided assistance and support*** in the areas of self-care, sensory/motor

development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, money management and household responsibilities. Also included are the salary, benefits, and training costs of direct program staff, supervisory staff, and purchased personnel who provide services in these areas;

- Habilitation supplies and equipment that are not specifically prescribed for one individual;
- Necessary staff supervision up to 24-hours a day; and
- Agency administration for habilitation services.

Group homes must maintain staffing per resident ratios according to requirements detailed in 9 CSR Chapter 40.

In some cases, client transportation is included in the rate when the facility is equipped to routinely provide rides to ~~**Independent Living Skills Development**~~ ***Day Habilitation Services*** provided at a stand-alone licensed or certified ~~**Independent Living Skills Development**~~ ***Day Habilitation*** provider, which is not physically connected to the participant's residence or to Community Integration, etc. The DMH regional offices assure no duplication in payment for this service.

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

The service excludes the following:

- Services, directly or indirectly, provided by a member of the individual's immediate family;
- Routine care and supervision which would be expected to be provided by a family or group home provider;
- Activities or supervision for which a payment is made by a source other than Medicaid; and
- Room and board costs.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Community Residential Facility
				Semi-Independent Living Arrangement

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community Residential Facility	9 CSR 40-1,2,4, 5	9 CSR 45-5.010; CARF, CQL or Joint Commission	DMH Contract; Staff qualifications are in DMH contract and are summarized as follows: Must be 18 years of age; have a high school diploma or its equivalent; training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care; training in the implementation of each individual's service plan within one month of employment; training in positive behavior support curriculum approved by

			the Division of DD within 3 months of employment. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.
Semi-Independent Living Arrangement	9 CSR 40-1,2,4,7	9 CSR 45-5.010; CARF, CQL or Joint Commission	DMH Contract; Staff qualifications are in DMH contract and are summarized as follows: Must be 18 years of age; have a high school diploma or its equivalent; training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care; training in the implementation of each individual's service plan within one month of employment; training in positive behavior support curriculum approved by the Division of DD within 3 months of employment. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community Residential Facility	Regional Office	Prior to DMH contract approval ~~or~~ *and* renewal; as needed based on service monitoring concerns
Semi-Independent Living Arrangement	Regional Office	Prior to DMH contract approval or *and* renewal; as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***04 Day Services***	Sub-Category 1: ***04010 Prevocational Services***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition (Scope)**:** ~~**Job Preparation**~~ ***Prevocational Services***

~~**Job preparation services provide training and work experiences intended to teach an individual the skills necessary to succeed in paid community employment. Skill training may include volunteerism, following directions, focusing on tasks, completing tasks, achieving productivity standards and quality results, responding appropriately to supervisors/co-workers, attendance and punctuality, problem solving, safety, mobility, or short term work trials. Training may also address workplace social skills necessary for successful community employment such as appropriate work place attire, hygiene, and interaction with co-workers and supervisors, acceptable work behaviors and other skills such as accessing transportation and connecting to community resources as it relates to obtaining employment. This service should be a pathway towards individualized employment and is dependent on individuals demonstrating progress towards employment over time.**~~

~~**Services may be provided on site or off site in the community. Group job preparation service may include serving up to six individuals at a time. With written approval from the Regional Office Director the group size may be up to eight (8) individuals.**~~

~~**Transportation costs for Job Preparation services are included in the unit rate, but costs for transporting to and from the residence are not included.**~~
~~**Job preparation services must comply with 42 CFR §440.180(c) (2) (i). The need for services must be documented in the individual's service plan. Services must be primarily habilitation in nature.**~~

Prevocational Services provide one-to-one learning and group experiences to further develop an individual's general, non-job-task-specific skills which are needed to succeed in paid employment in competitive, integrated community settings. Services are expected to occur over a defined period of time with specific and measurable outcomes to be achieved, as determined by an individualized assessed need through an ongoing person-centered planning process.

Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

- ***Prevocational Services should enable each individual to attain the highest level of independence and autonomy in the most integrated competitive employment setting and with a job matched to the individual's interests, strengths, priorities, abilities, and capabilities.***
- ***Participation in Prevocational Services is not a required pre-requisite for supported employment services provided under the waiver. Prevocational services should only be authorized when an individual is otherwise unable to directly enter the general workforce as a result of an underdeveloped or undeveloped general, non-job-task-specific skill(s).***
- ***Prevocational Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform competitive work in community integrated employment.***
- ***Services must be provided in a community workplace setting or at a licensed, certified or accredited facility of a qualified employment service provider. The setting for the delivery of services must be aligned with the individualized assessed need and that which is most conducive in developing the specific and measurable outcomes contained within the individual support plan. Services cannot be provided within an individual's residence. Prevocational services can be provided in small groups not exceeding four (4) individuals at a time. The decision to provide services in a group setting must be based on individualized assessed need and be supported in the person centered plan as being the most***

autonomous setting which facilitates the highest levels of individual learning.

- ***Vocational services, which are not covered through waivers, are services that teach job task specific skills required by a participant for the primary purpose of completing those tasks for a specific facility based job and are not delivered in an integrated work setting through supported employment. The distinction between vocational and pre-vocational services is that prevocational services, regardless of setting, are delivered for the purpose of furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage. These goals are described in the individual's person centered services and supports plan and are designed to teach skills that will lead to integrated competitive employment.***
- ***A person receiving prevocational services may pursue employment opportunities at any time to enter the general work force.***
- ***Individuals participating in prevocational services may be compensated in accordance with applicable Federal laws and regulations and the provision of prevocational services is always delivered with the intention of leading to permanent integrated employment at or above the minimum wage in the community.***
- ***All prevocational service options should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals.***
- ***Personal assistance may be a component of prevocational services, but may not comprise the entirety of the service.***
- ***Transportation costs for Prevocational Services are included in the unit rate, but costs for transporting to and from the residence are not included.***
- ***Individuals who receive prevocational services may also receive supported employment and/or day habilitation services. A participant's person-centered service plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.***
- ***Prevocational services may include volunteer work, such as volunteer learning and training activities that prepare a person for entry into the paid workforce.***
- ***Prevocational Services furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 and its amendments or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Therefore, the case record for any individual receiving this service must document the individual is not eligible for, unable to access, exhausted services or otherwise inapplicable for the aforementioned programs as outlined in an interagency memorandum of understanding.***
- ***Prevocational services must comply with 42 CFR §440.180(c) (2) (i).***

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

Must be authorized based upon individual need not to exceed 60 quarter-hour units per week. Prevocational Services must not exceed 6 months. Additional units or monthly increments beyond 6 months must be pre-authorized by the Division's Regional Director or designee.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications				
Provider	☐	Individual. List types:	✓	Agency. List the types of agencies:

Category(s) *(check one or both)*:		~~**Day Habilitation Provider**~~
		~~**Community Employment**~~ ***Employment Service Provider***

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
~~**Day Habilitation Provider**~~		~~**Certified by DMH under 9 CSR 45-5.010; Accredited by the CARF in the area of Personal, Social and Community Services; or accredited by CQL or Joint Commission**~~	~~**DMH Contract;**~~ ~~**Staff qualifications are in DMH contract and are summarized as follows:**~~ ~~**Must be 18 years of age; have a high school diploma or its equivalent; training in preventing, detecting, and reporting of abuse and neglect prior to providing direct**~~ ~~**care; training in the implementation of each individual's service plan within one month of employment; training in positive behavior support curriculum approved by the Division of DD within 3 months of employment. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.**~~
~~**Community**~~ **Employment** ***Services Provider***	~~**9 CSR 30-5.050**~~	9 CSR 45-5.010 certification; CARF, CQL or Joint Commission accreditation	DMH Contract; Staff qualifications are in DMH contract and are summarized as follows: Must be 18 years of age; have a high school diploma or its equivalent; training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care; training in the implementation of each individual's service plan within one month of employment; training in positive behavior support curriculum approved by the Division of DD within 3 months of employment. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
~~**Day Habilitation**~~	~~**Regional Office**~~	~~**Prior to contract approval or**~~

~~**Provider**~~		~~**renewal; as needed based on service monitoring concern**~~
~~**Community**~~ **Employment** ***Services Provider***	**Regional Office**	**Prior to contract approval** ~~**or**~~ ***and*** **renewal; as needed based on service monitoring concern**

Service Specification	
HCBS Taxonomy	
Category 1: ***03 Supported Employment***	Sub-Category 1: ***03021 Ongoing Supported Employment, Individual***
Category 2: ***03 Supported Employment***	Sub-Category 2: ***03022 Ongoing Supported Employment, Group***
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:** ~~**Community Employment**~~ ***Supported Employment***	

~~**Community**~~ ***Supported employment is a support service to facilitate competitive work in an integrated work setting.*** ~~**Through ongoing support services for individuals with developmental disabilities.**~~ **The service must be identified in the individual's service plan based upon an individualized assessed need which promotes the greatest degree of integration, independence and autonomy. Models of** ~~**community**~~ **supported employment may include individual support** ~~**jobs**~~ **or group support such as** ~~**enclaves (a cluster of jobs in an integrated setting, such as a plant)**~~ ***community business-based work groups and or mobile crews. Individual and group services are defined separately below.***

For those individuals whose individualized assessed need supports self-employment, Supported Employment Individual employment supports may include services and supports that assist the individual in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include:

- ***Aide to the individual in identifying potential business opportunities;***
- ***assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; and***

identification of the supports that are necessary for the individual to operate the business.

~~**Community employment is competitive work in an integrated work setting with on-going support services for individuals with developmental disabilities. The service must be identified in the individual's service plan. Models of community employment may include individual jobs or group such as enclaves (a cluster of jobs in an integrated setting, such as a plant), and mobile crew. Individual and group services are defined separately below.**~~

Supported Employment- Individual Supported Employment ~~**Individual Community Employment**~~:

~~**Community employment services are delivered in the community at large when seeking employment and**~~

~~**in integrated business work settings (including self-employment situations) where the individual with a developmental disability has chosen to become employed. Ongoing support consists of continuous or periodic job skill training as specified in the individual's service plan to enable the individual to perform the work.**~~ **Individual Supported Employment services are the ongoing supports to individuals and their employers who, because of their disabilities, need intensive on-going support to maintain a job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.**

Supported Employment - Individual Supported Employment services may include:

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

For those individuals whose individualized assessed need supports self-employment, Supported Employment Individual employment supports may include services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include ongoing assistance, counseling and guidance once the business has been launched.

~~**Community Employment services may include:**~~

- ~~**Individualized job development and placement;**~~
- ~~**On-the-job training in work and work-related skills;**~~
- ~~**Ongoing supervision and monitoring of the person's performance on the job; and**~~
- ~~**Training in related skills needed to obtain and retain employment such as using community resources and public transportation. While other services may also provide training in using community resources and public transportation, this particular training component is directly related to obtaining employment. While a waiver participant's ISP may also include other services that provide training in using community resources and public transportation, documentation will clearly indicate no duplication in services, in accordance with 13 CSR 70-3.030(2)(A) 6. requiring a begin and end time for services reimbursed according to time spent in service delivery.**~~

~~**Group Employment:**~~

~~**Group employment services are delivered in regular business and industry settings for groups of no more than six (6) workers with disabilities. With written approval from the Regional Office Director the group size may be up to eight (8) workers. Examples include enclaves and mobile work crews. The outcome of this service is sustained paid employment.**~~

~~**Group Employment services may include:**~~

- ~~**job development and placement;**~~
- ~~**On-the-job training in work and work-related skills;**~~
- ~~**Ongoing supervision and monitoring of the person's performance on the job; and**~~

- ~~**Training in related skills needed to obtain and retain employment such as using community resources and public transportation.**~~

Supported Employment -Small Group Employment Support:

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

Supported Employment – Small Group Employment Supports may include:

- ***On-the-job training in work and work-related skills; i.e. job coaching to facilitate the acquisition, and ongoing performance, of the essential functions of the job and the facilitation of natural supports (i.e. fading).***
- ***Ongoing supervision and monitoring of the person's performance on the job; i.e. evaluating self-maintenance strategies, work production and the effectiveness of natural supports (i.e. fading) which promote the greatest degree of inclusion, integration and autonomy.***

Training in related skills needed to retain individual integrated community-based employment; i.e. supporting and facilitating strategies which promote attendance and social inclusion in the workplace based upon individualized assessed need such as using community resources and public transportation.

Additional Information about *Supported* Employment services:

~~**When participants are compensated they must be paid in accordance with the United States Fair Labor Standards Act (USFLSA) of 1985**~~

- ***Supported employment services must be provided in a manner that promotes integration into the workplace and interaction between individuals and people without disabilities in those workplaces while maintaining the individual's rights of dignity, privacy and respect.***
- ***All Supported Employment service options should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's assessed goals, needs, interests and preferences. Supported Employment Group is not appropriate for individuals who demonstrate the capacity, ability and interest to work independently. An individual's autonomy and independence to perform employment with the least amount of restrictions must be supported through the person centered planning process.***
- ***Participants must be compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.***
- ***Supported Employment furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 and its amendments or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Therefore, the case record for any individual receiving this service must document the individual is***

not eligible for, unable to access, exhausted services or otherwise inapplicable for the aforementioned programs as outlined in an interagency memorandum of understanding.

Supported Employment supports do not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business or otherwise covered under the Americans with Disabilities Act.

- ~~Personal care/assistance may be a component of employment services, but may not comprise the entirety of the service.~~ Individuals who receive ***Supported*** Employment ~~job discovery and preparation services~~ may also receive other day services. An individual's support plan may include two or more types of non-residential services. However, any combination of non-residential services may not be billed during the same period of the day.
- ***Personal Assistance may be a component of an individual's employment retention support plan for assistance with ADL's and IADLS. However, Personal Assistance may not be used in lieu of Supported Employment services as defined above.***
- **Transportation costs are not included in the *supported* ~~community~~ employment fee, but specialized transportation is available as a separate service if necessary.**

~~**The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore, the case records for individuals receiving community employment services under the waiver will document that the participant was denied benefits by the Missouri Department of Elementary and Secondary Education, Office of Adult Learning and Rehabilitation Service (VR), exhausted VR benefits (nine months is the maximum in Missouri), VR does not cover the specific employment service the individual requires, or the person requests supports from a provider that does not participate in VR's system. The service coordinator's documentation of VR's failure to confirm a denial of benefits in writing within 30 days of verbal notification may also serve as evidence of eligibility for community employment services.**~~

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

1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a ***supported*** ~~**community**~~ employment program; ***or***
2) Payments that are passed through to users of community employment programs. ~~**or 3) payments for training that is not directly related to an individual's community employment program.**~~

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

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or*	☐	Individual. List types:	✓	Agency. List the types of agencies:
				~~**Supported**~~ Employment ***Services Provider***

State:	
Effective Date	

both):		

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
~~**Supported**~~ **Employment** ***Services***	~~**9 CSR 30-5.050**~~	9 CSR 45-5.010 certification; CARF, CQL or Joint Commission accreditation	DMH Contract; Staff qualifications are in DMH contract and are summarized as follows: Must be 18 years of age; have a high school diploma or its equivalent; training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care; training in the implementation of each individual's service plan within one month of employment; training in positive behavior support curriculum approved by the Division of DD within 3 months of employment. Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
~~**Supported**~~ Employment ***Services***	Regional Office	Prior to contract approval ***or*** ~~**and**~~ renewal; as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***09 Care Giver Support***	Sub-Category 1: ***0912 Respite, In-Home***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope): In Home Respite
In-home respite care is provided to individuals unable to care for themselves, on a short-term basis, because of the absence or need for relief of those persons normally providing the care. To be eligible for in-home respite care, the persons who normally provide care to the individual must be other than formal, paid caregivers. This service is not delivered in lieu of day care for children nor does it take the place of day habilitation programming for adults. While ordinarily provided on a one-to-one basis, in-home respite may include assisting up to three individuals at a time. The only limitation on total hours provided is that they be necessary to avoid institutionalization and remain within the overall cost effectiveness of each individual's service plan. The service is provided in the individual's place of residence ***or in a licensed/certified/accredited facility when service is provided in interim periods, at the discretion of the individual/guardian/family, which does not include overnight care.*** If the service includes overnight care, it must be provided in the individual's place of residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit of service is 15 minutes or one day. The only limitation on total hours provided is that they be necessary to avoid institutionalization and remain within the overall cost effectiveness of each individual's plan.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Independent Contractor		Residential Habilitation	
			Day Habilitation	
			Individualized Supported Living Services	
			Medicaid State Plan personal care, respite, or homemaker services provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Independent Contractor	Missouri State professional license such as RN or LPN		DMH Contract; Shall not be the consumer's spouse; a parent of a minor child (under age 18); nor a legal guardian
Residential Habilitation	9 CSR 40-1,2,4,5 9 CSR 40-1,2,4,7	9 CSR 45-5.010; CARF; CQL; or Joint Commission	DMH Contract; The agency-based provider of respite must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; the planning team may specify additional qualifications and training necessary to carry out the service plan.
Day Habilitation	9 CSR 40-1,2,9	9 CSR 45-5.010;	DMH Contract;

		CARF; CQL; or Joint Commission	The agency-based provider of respite must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; the planning team may specify additional qualifications and training necessary to carry out the service plan.
Individualized Supported Living Services	9 CSR 40-1,2,4,6	9 CSR 45-5.010; CARF; CQL; or Joint commission	DMH Contract; The agency-based provider of respite must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; the planning team may specify additional qualifications and training necessary to carry out the service plan.
Medicaid State Plan personal care, respite, or homemaker services provider			Medicaid Personal Care Provider Agreement; DMH Contract; DMH Contract; The agency-based provider of respite must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; the planning team may specify additional qualifications and training necessary to carry out the service plan.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Independent Contractor	Regional office staff	Prior to signed contract; as needed based on service monitoring concerns and as consumer needs change; ***regional office monitors every three years***
Residential Habilitation	Agency verifies qualification of relatives employed by agencies; oversight by Regional Office	Agency verifies upon hiring and as needed based on supervision; regional office monitors provider ~~**annually**~~ ***every three years.***
Day Habilitation	Agency verifies qualification of relatives employed	Agency verifies upon hiring and

	by agencies; oversight by Regional Office	as needed based on supervision; regional office monitors provider ~~annually~~ ***every three years***
Individualized Supported Living Services	Agency verifies qualification of relatives employed by agencies; oversight by Regional office	Agency verifies upon hiring and as needed based on supervision; regional office monitors provider ~~annually~~ ***every three years.***
Medicaid State Plan personal care, respite, or homemaker services provider	Agency verifies qualification of relatives employed by agencies; oversight by Regional office	Agency verifies upon hiring and as needed based on supervision; regional office monitors provider ~~annually~~ ***every three years.***

Service Specification	
HCBS Taxonomy	
Category 1: ***14 Equipment, technology, and modifications***	Sub-Category 1: ***14031 Equipment and Technology***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**: Assistive Technology**	

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

Electronic ~~**surveillance/monitoring**~~ ***support*** systems using video, web-cameras, or other technology is only available on an individual, case-by-case basis when an individual requests the service and the planning team agrees it is appropriate and meets the health and safety needs of the individual. Remote ~~**monitoring**~~ ***support*** technology may only be used with full consent of the individual and his/her guardian and with written approval by the ~~**human rights**~~ ***due process*** committee ~~**(HRC)**~~ ***when applicable to verify that due process was followed for the remote support request.***

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

The type of equipment and where ~~**monitors are**~~ placed will depend upon the needs and wishes of the individual

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

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

Waiver participants interested in electronic ~~**surveillance/remote**~~ ***support*** ~~**monitoring**~~ technology must be assessed for risk following the division's risk assessment guidelines posted at http://dmh.mo.gov/docs/dd/riskguide.pdf and must be provided information to ensure an informed choice about the use of equipment versus in-***home*** ~~**person**~~ support staff.

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

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

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

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

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

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

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

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

may be slightly different than a PERS) text-to-speech software, devices that enhance images for people with low vision, intercom systems.

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

Costs are limited to ~~$3,000~~ ***$9,000*** per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Electronic Communication Equipment and Monitoring Company

Provider Qualifications

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

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

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Electronic Communication Equipment and Monitoring Company	Regional Offices	Prior to contract approval ~~**or renewal; service review every 2 years**~~; as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***10 Other Mental Health and Behavioral Services***	Sub-Category 1: ***10040 Behavior Support***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:** ~~**Behavior Analysis Service**~~ ***Applied Behavior Analysis***

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

- ~~**An individual's Behavior Analysis Services are based on the Functional Behavioral Assessment which identifies functional relationships between behavior and the environment including contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical variables related to the challenging behavior or situations.**~~
- ~~**The plan should describe strategies and procedures to generalize and maintain the effects of the**~~

~~**behavior support plan and to collect data to assess the effectiveness of the plan and fidelity of implementation of the plan.**~~

- ~~**The specific skills and behaviors targeted for each individual should be clearly defined in observable terms and measured carefully by direct observation each session.**~~
- ~~**The service shall include monitoring of data from continuous assessment of the individual's skills in learning, communication, social competence, and self-care guide to the scope of the individual support plan, which must include separate, measurable goals and objectives with clear definitions of what constitutes mastery.**~~
- ~~**Data should be displayed in graphic format with relevant environmental variables that might affect the target behaviors indicated on the graph. The graph should provide indication of analysis via inclusion of environmental variables including medications and changes in medications, baseline or pre-intervention levels of behavior, and strategy changes.**~~
- ~~**Performance based training for parents, caregivers and significant others in the person's life is also part of the behavior analysis services if these people are integral to the implementation or monitoring of the plan.**~~

~~**Senior Behavior Consultant and Behavior Intervention Specialist may be authorized in conjunction with a Functional Behavioral Assessment (FBA), which is a separate service, cost and code. The purpose of the FBA is to gather information in the form of data from descriptive assessment, observation and/or systematic manipulation of environmental variables, written and oral history of the individual. The information from the FBA should lead to identification of possible controlling and contributing variables, and possible proactive, preventative and reactive strategies for the identified challenges of the individual referred for Behavior Analysis Services.**~~

~~**NOTE: The Behavior Analysis Service is not intended to be an ongoing service. The following guidance shall be used when submitting authorizations to the Utilization Review Committee: Initial authorization for Behavior Analysis Service may not exceed 180 days,**~~

- ~~**One subsequent authorization for Behavior Analysis Service may be approved, not to exceed an additional 90 days,**~~
- ~~**Additional authorizations for Behavior Analysis Service must be approved by the Division Deputy Director or Assistant Director.**~~

~~**Behavior Analysis Service may be authorized concurrent with Person Centered Strategies Consultation if working in conjunction with this service to support improved quality of life as foundation for behavioral services.**~~

~~**Senior Behavior Consultant:**~~

~~**The service consists of design, monitoring, revision and/or brief implementation of 1:1 behavioral interventions described in the individual's behavior support plan.**~~

~~**The service is designed to be utilized for situations involving complex behavioral issues such as severe aggression or self injury or when multiple behavioral challenges have been identified, many interventions have been unsuccessful or the challenges have a long history of occurrence. The Behavior Analysis service provides advanced expertise and consultation at critical points in the service delivery to achieve specific ends in the service delivery process such as assess a complex problem behavior, problem solve the lack of progress, or regression in the intervention. Ongoing management of behavior analysis services might generally be provided by the Behavior Intervention Specialist. Evaluation of these data is used to revise the individual's support plan and accompanying services to ensure the best outcome for the**~~

~~**individual. Implementation of the behavior support plan may occur with all levels of this service, i.e., with the Behavior Intervention Specialist, with personal assistants, and/or with the family members.**~~

~~**Behavior Intervention Specialist:**~~

~~**Provides ongoing management of behavior analysis services. In more complex or involved situations the Behavior Intervention Specialist is responsible for managing the direct implementation of the recommendations and strategies of a Behavior Analysis service, participating in the development of the behavior support plan and document as a team participant. In these more complex cases the Behavior Intervention Specialist serves as a "bridge" between the Senior Behavior Consultant and the other service providers and family and supports of the individual receiving services. In cases which do not require the advanced services of a Senior Behavior Consultant the Behavior Intervention Specialist may provide the Functional Behavioral Assessment and Behavioral Services without the oversight of a Senior Behavior Consultant except as required by licensure law and professional standards (BCABA practice standards require supervision by a BCBA). At a minimum, the Behavior Intervention Specialist will provide face-to-face in-home training on the behavior support plan to families and/or primary caregivers who have responsibility for implementing the behavior support plan in the home or community setting. This shall include training for meals, hygiene, school and/or community activities, and evenings and weekends noted in the behavior support plan as particularly challenging. Ongoing management of a behavior support plan is a key role for a Behavior Intervention Specialist. Ongoing management involves collecting and analyzing data for the effectiveness of the behavior support plan, fidelity of implementation of the behavior support plan and reliability of the data, adjustment or revision of the strategies identified in the behavior support plan, training caregivers and family members on the implementation of the behavior support plan, and on occasion implementation of the behavior support plan when complicated techniques are involved or for short trial periods to determine if the plan is viable and as part of the training of the main implementers for the behavior support plan.**~~

~~**Functional Behavioral Assessment:**~~

~~**Functional Behavioral Assessment is a comprehensive and individualized strategy to identify the purpose or function of an individual's behavior, develop and implement a plan to modify variables that maintain the problem behavior, and teach appropriate replacement behaviors using positive interventions. The Functional Behavioral Assessment (FBA) which identifies functional relationships between behavior and the environment including contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical variables related to the challenging behavior or situations. The FBA provides information necessary to develop strategies and recommendations to proactively address the challenging behaviors through skill development, prevention of problem situations and contributing reactions and interactions with significant persons in the life of the individual. These recommendations and strategies are more thoroughly delineated in the person's behavior support plan.**~~

~~**The process of the FBA includes gathering a written and oral history of the individual including data, interview of significant individuals who have been involved with the person during times of challenging behaviors as well as times when the person does not have challenging behaviors, observation of the person in a variety of situations, data collection and review, and for the most complex behaviors and situations a systematic manipulation of possible controlling and contributing variables. This information gathering process should lead to identification of possible controlling and contributing variables, and possible proactive, preventative and reactive strategies for the identified challenges of the individual referred for Behavior Analysis Services.**~~

~~**There will be situations in which an assessment will be needed to determine if other services or if behavior**~~

~~**services might be appropriate. Not every instance of assessment will lead to behavioral services. If changes in situations occur, a new assessment may be warranted.**~~

~~**The FBA differs significantly from the Level of Care (LOC) assessment. The Level of Care assessment is performed by a Supportservice coordinator, also known as a case manager of Targeted Case Management services under 1915(g) of the Medicaid State Plan. LOC assessments are used strictly to determine an individual's eligibility for waiver services in accordance with 42 CFR Section 441.302(c) and detailed in Appendix B-6 of this waiver application.**~~

~~**SupportService coordinators (TCM case managers) conducting LOC assessments are required to have the following minimum education and experience:**~~

~~**1. One or more years of professional experience as (a) a registered nurse, (b) in social work special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, or speech therapy or a closely related area, or (c) in providing direct care to people with DD; AND**~~

~~**2. A bachelor's degree from an accredited college or university with a minimum of 24 semester hours or 36 quarter hours of credit in one or a combination of human service field specialties. Additional experience as a registered nurse may substitute on a year for year basis for a maximum of two years of required education.**~~

~~**These requirements are the same as are required for the Missouri state merit position of Case Manager I. Anyone who has worked for the state as a Case Manager I, or who is on the register for Case Manager I is considered to have met the requirements as a TCM Case manager, also called a Supportservice coordinator.**~~

~~**The FBA is a diagnostic assessment. Behavior analysts (including both senior consultant and behavior intervention specialist) conducting the FBA must be licensed in the State of Missouri (20 CSR 2063-4.005; 20 CSR 2063-5.010).**~~

~~**While information included in the FBA may be used to inform the LOC assessment, the FBA itself cannot substitute for the LOC assessment. Information included in the LOC assessment may also be reviewed and considered by the behavior analyst while conducting a FBA, however an LOC assessment cannot substitute for the FBA assessment.**~~

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

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

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

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

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

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

ABA services consist of the following components:

- ***Assessment: ABA services are bases on an assessment which identifies functional relationships between behavior and the environment, including contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical variables related to challenging behaviors or situations. The assessment is further composed of the following elements:***
    - ***Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.***
    - ***Observational Follow-up Assessment: Behavioral follow-up assessment(s) may be required to enable the Qualified Health Care Professional (QHCP) to finalize or fine-tune the baseline results and plan of care that were initiated in the identification assessment. This service is performed by a technician under the direction of a QHCP or licensed assistant behavior analyst. The QHCP or licensed assistant behavior analyst may or may not be on-site during the face-to-face assessment process. Observational Follow-up is provided to individuals who present with specific destructive behavior(s) (e.g., self-injurious behavior, aggression, property destruction) or behaviors or deficits in communication or social relatedness. Observational Follow-up includes the use of structured observation and/or standardized and non-standardized tests to determine levels of adaptive behavior. Areas assessed may include cooperation, motivation, visual understanding, receptive and expressive language, imitation, requests, labeling, play and leisure and social interactions. Specific destructive behavior(s) assessments include structured observational testing to examine events, cues, responses, and consequences associated with the behavior(s).***
    - ***Exposure Follow-up Assessment: is administered by the QHCP with the assistance of one or more technicians. Exposure behavioral follow-up assessment includes the Qualified Health Care Professional's interpretation of results, discussion of findings and recommendations with primary caregiver(s), and preparation of report. Typical individuals for these services***

include those with more specific severe destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction). Specific severe destructive behavior(s) are assessed using structured testing to examine events, cues, responses, and consequences associated with the behavior. Exposure Behavioral Follow up Assessment includes exposing the individual to a series of social and environmental conditions associated with the destructive behavior(s). Assessment methods include using testing methods designed to examine triggers, events, cues, responses, and consequences associated with the before mentioned maladaptive behavior(s). This assessment is completed in a structured, safe environment.

- ***Treatment: Adaptive Behavior Treatment addresses the individual's specific target problems and treatment goals as defined in previous assessments. Adaptive behavior treatment is based on principles including analysis and alteration of contextual events and motivating factors, stimulus-consequence strategies and replacement behavior and monitoring of outcomes. Goals of adaptive behavior treatment may include reduction of repetitive and aberrant behavior, and improved communication and social functioning. Adaptive behavior skill tasks are often broken down into small, measurable units, and each skill is practiced repeatedly until the individual masters it. Adaptive behavior treatment may occur in multiple sites and social settings (e.g., controlled treatment programs with individual alone or in a groups setting, home, or other natural environment). All ABA services are considered short term services whose objectives are to provide changes in patterns of interactions, daily activities and lifestyle including provider family/staff/caregivers skills to teach the individuals supported adaptive skills and skills to more appropriately address problem behaviors. The development of skills in the individual and in the family/staff/caregivers is a key component to these services. In addition it is the essential that the strategies developed are adapted to more typical types of support strategies so that the treatment plan called the BSP is replaced with these more typical strategies as the service is successful. Adaptive behavior treatment is further composed of the following elements:***
-
  - ***Adaptive Behavior Treatment by Protocol by Technician: is administered by a single technician or licensed assistant behavior analyst under the direction (on-site or off-site) of the Qualified Health Care Professional by adhering to the protocols that have been designed by the Qualified Health Care Professional. This service is delivered to the individual alone or while attending a group session.***
    Adaptive behavior treatment by protocol includes skill training delivered to an individual who, for example, has poor emotional responses (eg, rage with foul language and screaming) to deviation in rigid routines. The technician introduces small, incremental changes to the individual's expected routine along one or more stimulus dimension(s) , and a reinforce is delivered each time the individuals appropriately tolerates a given stimulus change until the individual tolerates typical variations in daily activities without poor emotional response.

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

  - ***Adaptive Behavior Treatment by Protocol Modification: Unlike the Adaptive Behavior Treatment by Protocol by Technician, Adaptive Behavior Treatment by Protocol Modification is administered by a QHCP or licensed assistant behavior analyst who is face-to-face with a single individual. The service may include demonstration of the new or modified protocol to a technician, guardian(s), and/or caregiver. For example, Adaptive Behavior Treatment by Protocol Modification will include treatment services provided to a teenager who is recently placed with a foster family for the first time and is experiencing a regression of the behavioral***

targets which were successfully met the group-home setting related to the individual's atypical sleeping patterns. The clinical social worker modifies the past protocol targeted for desired results to incorporate changes in the context and environment. A modified treatment protocol is administered by the qualified health care provider to demonstrate to the new caregiver how to apply the protocol(s) to facilitate the desired sleeping patterns to prevent sleep deprivation.

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

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

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

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

Limitations of the Observation Follow up Assessment: units are the first 30 minute of service and following 30 minutes. The first 30 minute units are limited to 5 per year, 1 per day and a maximum of 5 per week. The second 30 minute units are limited to 20 per year, 4 per day and 20 per week. These units can be done by the Registered Behavior Technician under the direction of the QHCP that is a Licensed Behavior Analyst, or under the direction of a Licensed assistant Behavior Analyst; the service can also be done by the QHCP or Licensed assistant Behavior Analyst.

Limitations of Adaptive Behavior by Protocol by Technician are the service must be performed by a Registered Behavioral Technician under the direction of a QHCP that is a Licensed Behavior Analyst. The service of Adaptive Behavior Treatment Protocol Modification must be provided concurrent to this service by a Licensed Behavior Analyst for at least the equivalent of 5% of the total units provided by the Registered Behavioral Technician

Limitations for Adaptive Behavior Treatment by Protocol Modification units are first 30 minutes and following 30 minutes for a service date. First 30 minutes are limited to 1 per day, 5 per week and 25

per month. Following 30 minute units are limited to 15 per day, 55 per week and 110 per month.

Limitations of Exposure Adaptive Behavior Treatment with Protocol Modification: this service can only be provided with prior approval by the Department of Mental Health, Division of Developmental Disabilities Chief Behavior Analyst. The units are first 60 minutes and the following 30 minute units of a service date. The first 60 minute units are limited to 1 per day, 5 per week and 25 per month and the following 30 minute units are limited to 15 per day, 55 per week and 110 per month.

Limitations of Family Adaptive Behavior Treatment Guidance: This service can be concurrent to any of the other treatment services. It is a 60 minute unit and is limited to 1 unit per day, 5 per week and 10 per month. In addition, no more than 8 Family members/guardians/caregivers can be present for a unit to be billed.

Limitations of Treatment Social Skills Group: This service can be concurrent to any of the other treatment services. It is a 90 minute unit and is limited to 1 unit per day, 5 per week and 10 per month. In addition no more than 8 individuals can be present for a unit to be billed.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Qualified Health Care Professional (QHCP)		Qualified Health Care Professional (QHCP)	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Qualified Health Care Professional (QHCP)	Graduate degree and Missouri State license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis. RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345;	Registration as Registered Behavior Technician with the Behavior Analyst Certification Board	DMH Contract;

	376.1224 Or Missouri State license as an assistant Behavior Analyst RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Qualified Health Care Professional (QHCP)	**Regional Office**	**Initially and at renewal**

Service Specification	
HCBS Taxonomy	
Category 1: ***03 Supported Employment***	Sub-Category 1: ***03010 Job Development***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:** ~~**Co-Worker Supports**~~ ***Job Development***	
~~**The service allows the Division of DD, designated provider agencies to contract with a business to provide Co-Worker Supports as a part of the natural workplace. The supports will be provided directly to an individual to assist in the development of positive work-related habits, attitudes, skills and work etiquette directly related to their specific employment, as well as assisting the individual to become a part of the**~~	

~~**informal culture of the workplace. Co-Worker Supports will include orienting the individual to health and safety aspects/requirements of their particular job. Individuals participating in this service are employed by a business and are paid minimum wage or better.**~~

~~**This service differs from Community Employment in that it creates opportunity for services/supports to be provided by the local business' employee where the individual is employed. A peer employee at a business where the person with a developmental disability is employed will have a better understanding of the businesses culture, the organizational structure, and the informal culture than will the DD professional who provides Community Employment. Receiving mentoring from a fellow employee increases opportunities for acceptance into and thus success in the workplace community.**~~

~~**It is intended to be of short duration.**~~

~~**This service enables a full continuum of job supports that could begin with job preparation, move to job discovery, then community employment with the least intensive support being provided through Co-Worker Supports. It is not necessary for an individual to progress along this continuum, however. Depending upon the individual's skills, abilities and needs, identified during the person-centered planning process, they may start at any point, skip steps in the continuum, or transition back into a service where more supports are available.**~~

~~**Throughout the length of a contract, per funding requirements and with the employer's knowledge, the Division of DD or contracted provider performs oversight, just as they do in other waiver services.**~~

~~**This service is over and above the obligations an employer has for an employee without a disability, but does not duplicate nor supplant those provided under the provisions of the Individuals with Disabilities Education Improvement Act, or Section 110 of the Rehabilitation Act of 1973, or the Americans with Disabilities Act.**~~

~~**An individual may not receive Job Discovery, Job Preparation, or Community Employment, at the same time they receive Co-Worker Supports. Individuals receive Co-Worker Supports services during their first six months of employment. Reimbursement may be extended up to 12 months on the job. After the first six months, the contract is reduced to a lower stabilization rate based on job support intervention needed**~~

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

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

Job Development services may include:

- ***Application completion assistance with the individual,***
- ***Job interviewing activities with the individual,***
- ***Completion of task analysis with or without the presence of the individual based upon individualized need,***

Negotiation with prospective employers and education of prospective employers of their role in promoting full inclusion with or without the presence of the individual based upon individualized need.

Additional Information about Job Development services:

- ***Job Development services must be provided in a manner that promotes integration into the workplace and***

interaction between participants and people without disabilities in those workplaces while maintaining the participant's rights of dignity, privacy and respect.

- ***Job Development should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. This service and support should be designed to support a successful employment outcome consistent with the individual's assessed goals, needs, interests and preferences. An individual's autonomy and independence to perform employment with the least amount of restrictions must be supported through the person centered planning process.***
- ***Participants must be compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.***
- ***Job Development furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 and its amendments or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Therefore, the case record for any individual receiving this service must document the individual is not eligible for, unable to access, exhausted services or otherwise inapplicable for the aforementioned programs as outlined in an interagency memorandum of understanding.***

- ***Individuals who receive Job Development may also receive other day services. An individual's support plan may include two or more types of non-residential services. However, any combination of non-residential services may not be billed during the same period of the day. Transportation costs are not included in the Job Development fee, but specialized transportation is available as a separate service if necessary.***

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

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

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

~~**An individual may not receive Job Discovery, Job Preparation, or Community Employment, at the same time they receive Co-Worker Supports. Individuals receive Co-Worker Supports services during their first six months of employment. Reimbursement may be extended up to 12 months on the job. After the first six months, the contract is reduced to a lower stabilization rate based on job support intervention needed.**~~

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

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications				
Provider	☐	Individual. List types:	✓	Agency. List the types of agencies:

Category(s) *(check one or both)*:		***Employment Services Provider*** ~~**Community Employer of Individual Service**~~

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Employment Services ~~**Community Employer of Individual Service**~~		9 CSR 45-5.010 certification; CARF, CQL or Joint Commission accreditation	***DMH Contract;*** ***Staff qualifications are in DMH contract and are summarized as follows:*** ***Must be 18 years of age; have a high school diploma or its equivalent; training in*** ***preventing, detecting, and reporting of abuse and neglect prior to providing direct*** ***care; training in the implementation of each individual's service plan within one month of*** ***employment; training in positive behavior support curriculum approved by the Division*** ***of DD within 3 months of employment. Additionally staff administering medication*** ***and/or supervising self-administration of meds must have successfully met the*** ***requirements of 9 CSR 45-3.070.*** ~~**DMH contract;**~~ ~~**To qualify, a description of supports to be provided by the subcontractor must be reviewed and accepted by the personal support team, including the service coordinator and other members designated by the individual, and the individual or his or her legal guardian prior to its execution.**~~ ~~**These subcontracts are approved when it is determined that the individuals needs are best met by supports that supplement those provided by industry employees.**~~ ~~**The provider must be a employer that is register with the Missouri Secretary of**~~

			~~**State as a business in good standing.**~~

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Employment Services ~~**Community Employer of Individual Service**~~	**Regional Office**	Prior to contract approval ~~**or renewal(annually);**~~ ***every three years;*** as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:** ~~**Communication Skills Instruction**~~

~~**Communication Skills Instruction services are intended to train individuals with minimal language skills (MLS) to use systematic communication. Individuals with MLS are deaf persons who know neither English nor American Sign Language (ASL), nor have any other formal communication system. This service is used to help individuals with multiple developmental disabilities communicate with the people around them, a critical skill for community survival and exercising choice and self-determination.**~~

~~**Communication skills instruction includes both assessment/evaluation and training. An initial assessment of an individual's communication skills is performed to determine the need for instruction. It measures the number of ASL or home signs used; finger spelling capacity; degree of "parroting;" use of gesture, mime, writing on paper; attention span; facial expressions; and consistency in communication with a variety of others, both deaf and hearing. Evaluation of the outcome of the instruction occurs at six month intervals: this includes evaluation of communication skills in social, vocational and leisure situations, behavioral changes, and need for continued instruction and/or other intervention.**~~

~~**Communication skills instruction includes teaching a new communication system or language or enhancing a deaf individual's established minimal language skills, based on the formal assessment of communication skills. Instruction sessions typically involve the people who support the deaf individual as well as the individual himself.**~~

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

This service is a cost effective alternative to placement in an ICF- ***ID~~MR~~***. The unit of service is 15 minutes.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or*	✓	Individual. List types:	☐	Agency. List the types of agencies:
	~~**Communication Skills Instructor**~~			

both):		

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
~~**Communication Skills Instructor**~~		~~**DMH certified as a Communication Assistant.**~~ ~~**Providers must be certified as a Communication Assistant by the Department of Mental Health, Bureau of Deaf Services. Certification is granted based on completion of a prescribed course of study offered through local interpreter training programs or during extended workshops held by the bureau.**~~	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

~~Communication Skills Instructor~~	**Regional Office**	**Prior to contract approval or renewal; as needed based on service monitoring concerns**

Service Specification	
HCBS Taxonomy	
Category 1: ***17 Other Services***	Sub-Category 1: ***17990 Other***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**: Community Specialist**

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

Community specialist services includes professional observation and assessment, individualized program design and implementation and consultation with caregivers. This service may also, at the choice of the individual designated representative, include advocating for the individual, and assisting the individual in locating and accessing services and supports within their field of expertise.

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

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

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

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

A unit of service is 1/4 hour.

Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may	☐	Legally	✓	Relative	☐	Legal Guardian

be provided by *(check each that applies):*		Responsible Person				

Provider Specifications				
Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Qualified Community Professional		State Plan Personal Care Provider	
			Individualized Supported Living	
			Day Habilitation	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
State Plan Personal Care Provider			DMH Contract; Agency employs an individual with a Bachelors degree from an accredited university or college plus one year experience, or a Registered Nurse (with an active license in good standing, issued by the Missouri State Board of Nursing), or an Associates degree from an accredited university or college plus three years of experience to direct or consult with its operation; DHSS Medicaid Personal Care Enrollment.
Individualized Supported Living		Certified by DMH under 9 CSR 45-5.010 or accredited by CARF, CQL or Joint Commission as a lead agency for Individualized Supported Living Services;	DMH Contract; employs and individual with a Bachelor's degree from an accredited university or college plus one year experience, or a Registered Nurse (with an active license in good standing, issued by the Missouri State Board of Nursing) or an Associates degree from an accredited university or college plus three years of experience.
Day Habilitation		Certified by DMH under 9 CSR 45-5.010 or accredited by CARF, CQL or Joint Commission	DMH Contract; employs an individual with a Bachelors degree from an accredited university or college plus one year experience, or a Registered Nurse (with an active license in good standing, issued by the Missouri State Board of Nursing) or an Associates degree from an accredited university or college plus three years of experience.
Qualified Community Professional			DMH Contract; An individual with a Bachelors degree from an accredited university or college plus one year experience, or a Registered Nurse (with an active license in good standing, issued by the Missouri State Board of Nursing) or an Associates degree from an accredited

			university or college plus three years of experience.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
State Plan Personal Care Provider	Regional Office	Prior to contract approval ~~**or renewal**~~**;** as needed based on service monitoring concerns
Individualized Supported Living	Regional Office	Prior to contract approval or ~~**renewal**~~ ***every three years*****;** as needed based on service monitoring concerns
Day Habilitation	Regional Office	Prior to contract approval or ~~**renewal**~~ ***every three years*****;** as needed based on service monitoring concerns
Qualified Community Professional	Regional Office	Prior to contract approval or ~~**renewal**~~ ***every three years*****;** as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***16 Community Transition Services***	Sub-Category 1: ***16010 Community Transition Services***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**: Community Transition**	

Transition services are one-time, set-up expenses for individuals who transition from an institution (ICF/***ID***~~**MR**~~ or Title XIX Nursing Home or other congregate living setting) to a less restrictive community living arrangement such as; a home, apartment, or other community-based living arrangement. ***Congregate living settings shall include any provider-owned residential setting where MO HealthNet reimbursement is available, including the following:***

- ***Intermediate Care Facilities for Individuals with Intellectual Disabilities***
- ***Nursing Facilities***
- ***Residential Care Facilities***
- ***Assisted Living Facilities***
- ***DD Waiver Group Homes***

Examples of expenses that may be covered include:
- Expenses to transport furnishings and personal possessions to the new living arrangement;
- Essential furnishing expenses required to occupy and use a community domicile;
- Security deposits that are required to obtain a lease on an apartment or home that does not constitute paying for housing rent;
- Utility set-up fees or deposits for utility or service access (e.g. telephone, water, electricity, heating, trash removal);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

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

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

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

Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Individual Contractor		Residential Habilitation Provider	
			Division of DD Regional Office	
			Agency Contractor	
			ISL Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Residential Habilitation Provider	9 CSR 40-1,2,4,7	9 CSR 45-5.010 certification; CARF; CQL; or Joint commission accreditation	DMH Contract
Division of DD			Meets OHCDS designation

Regional Office			
Agency Contractor	Applicable business license for service provided		Registered with Missouri Secretary of State in good standing; DMH Contract
Individual Contractor	Applicable business license for service provided		DMH Contract

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Residential Habilitation Provider	Regional Office	Prior to contract approval or ~~renewal~~ ***every three years*****;** as needed based on service monitoring concerns
Division of DD Regional Office	Regional Office; DMH Central Office Contract Unit	Prior to contract approval or renewal; as needed based on service monitoring concerns
Agency Contractor	Regional Office	Prior to contract approval or renewal; as needed based on service monitoring concerns
Individual Contractor	Regional Office	Prior to contract approval ~~**or renewal**~~**;** as needed based on service monitoring concerns
ISL Provider	Regional Office	Prior to contract approval or ***every three years*** ~~**renewal**~~**;** as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***10 Other Mental Health and Behavioral Services***	Sub-Category 1: ***10060 Counseling***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**: Counseling**	
Counseling Services include goal oriented counseling to maximize strengths and reduce behavior problems and/or functional deficits, which interfere with an individual's, personal, familial, and vocational or community adjustment. It can be provided to individuals and families when the consumer is present with the family. This service is not available to children who are eligible for psychology/counseling services reimbursed under the	

Healthy Children and Youth (EPSDT) program nor adults when State plan psychology services are appropriate to meet the individual's need.

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

The planning team ensures this service does not duplicate, nor is duplicated by, any other services provided to the individual. Counseling is a cost effective alternative to placement in an ICF- ~~**MR**~~ *ID*.

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

Counseling services are covered under the Medicaid state plan. They may only be covered under the waiver when a prior authorization request has been submitted to and denied by MO HealthNet.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Professional Counselor		Agency enrolled as a waiver provider employing psychologist, counselor or social worker licensed in accordance with RSMo. Chapter 337	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Professional Counselor	Psychologist, counselor or social worker licensed in accordance with RSMo. Chapter 337		DMH Contract
Agency enrolled as a waiver provider employing psychologist, counselor or social worker licensed in accordance with	Psychologist, counselor or social worker licensed in accordance with RSMo. Chapter 337		DMH Contract

RSMo. Chapter 337			

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Professional Counselor	Regional Office	Prior to contract approval or renewal; as needed based on service monitoring concerns
Agency enrolled as a waiver provider employing psychologist, counselor or social worker licensed in accordance with RSMo. Chapter 337	Provider records; Regional office oversight	Prior to contract approval or at renewal; as needed based on monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***10 Other Mental Health and Behavioral Services***	Sub-Category 1: ***10030 Crisis Intervention***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**: Crisis Intervention**

Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.

Crisis intervention may be provided in any setting and includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.

Individuals with developmental disabilities are occasionally at risk of being moved from their residences to institutional settings because the person, or his or family members or other caretakers, are unable to cope with short term, intense crisis situations. Crisis intervention can respond intensively to resolve the crisis and prevent the dislocation of the person at risk. The consultation which is provided to caregivers also helps to avoid or lessen future crises. This service is a cost effective alternative to placement in an ICF-~~**MR**~~ ***ID***.

Specific crisis intervention service components may include the following:
• Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other

factors contributing to the crisis;
• Assessing which components are the most effective targets of intervention for the short term amelioration of the crisis;
• Developing and writing an intervention plan;
• Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions, and following-up to ensure positive outcomes from interventions or to make adjustments to interventions;
• Providing intensive direct supervision when a consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others;
• Assisting the consumer with self care when the primary caregiver is unable to do so because of the nature of the consumer's crisis situation; and
• Directly counseling or developing alternative positive experiences for consumers who experience severe anxiety and grief when changes occur with job, living arrangement, primary care giver, death of loved one, etc.
Temporary day habilitation services as in a crisis drop in center
Temporary 24 hour care in a crisis bed of a residence

Providers of crisis intervention shall consist of a team under the direction and supervision of a psychologist, counselor or social worker, behavior analyst licensed by the State of Missouri (RSMo. 1994, Chapter 337). Alternately, the supervisor may be employed by the State of Missouri as a psychologist, clinical social worker, behavior analyst or in an equivalent position. All team members shall have at least one year of work experience in serving persons with developmental disabilities, and shall, either within their previous work experience or separately, have a minimum of 40 hours training in crisis intervention techniques prior to providing services.

Crisis teams may be agency based (certified or accredited ISL lead agencies, day habilitation providers, and group homes, or Division of DD regional offices and habilitation centers), or they may stand alone.

The scope of the waiver crisis intervention service is significantly above and beyond the scope of the state plan service and is meant to be provided by a team, not a single individual. It would be extremely rare for a crisis situation involving a DD waiver participant to be resolved within 60 minutes, and by a person without specialized training working with people with developmental disabilities. Many crisis situations in the DD system may be due to an environmental situation where the individual does not have the language skills to communicate their discomfort or distress, and the average provider of traditional "talk therapy" may not have the experience, skills and educational background to appropriately address this need.

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

Crisis Intervention services are expected to be of brief duration (4 to 8 weeks, maximum). When services of a greater duration are required, the individual should be transitioned to a more appropriate services program such as counseling, or respite.

Crisis intervention needs for the eligible person that can be met through state plan, including EPSDT crisis services, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Waiver crisis intervention shall be provided above and beyond any state plan, including EPSDT crisis service that can meet the individual's need.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications				
Provider	☐	Individual. List types:	✓	Agency. List the types of agencies:

Category(s) *(check one or both)*:		Division of DD Regional Offices & Habilitation Centers
		Crisis Agency
		ISL Lead Agency; Day Habilitation; or Residential Hab Provider Agency

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Division of DD Regional Offices & Habilitation Centers	Psychologist, Counselor or Social Worker licensed under RSMo Chapter 337;		Supervisor may be employed by the State of Missouri as a psychologist, clinical social worker or equivalent position exempt from licensure, but who meets the requirements of a QDDP.
Crisis Agency	Psychologist, Counselor or Social Worker licensed under RSMo Chapter 337		DMH Contract
ISL Lead Agency; Day Habilitation; or Residential Hab Provider Agency	Psychologist, Counselor or Social Worker licensed under RSMo Chapter 337		DMH Contract

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Division of DD Regional Offices & Habilitation Centers	Regional Office and DMH Contract Unit Staff	Prior to contract approval ~~**or renewal**~~; as needed based on service monitoring concerns
Crisis Agency	Regional Office	Prior to contract approval ~~**or renewal**~~; as needed based on service monitoring concerns
ISL Lead Agency; Day Habilitation; or Residential Hab Provider Agency	Regional Office	Prior to contract approval ~~**or renewal**~~; as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***14 Equipment, technology, and modifications***	Sub-Category 1: ***14020 Home and/or Vehicle Accessibility Adaptations***
Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**: Environmental Accessibility Adaptations-Home/Vehicle Modification**

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

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

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

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

Costs are limited to $7,500 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Contractor		Contractor	

Provider Qualifications

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

Contractor (Individual)			Must have applicable business license and meet applicable building codes; DMH Contract
Contractor (Agency)			Must have applicable business license and meet applicable building codes; DMH Contract

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Contractor (Individual)	Regional Office	Prior to contract approval or renewal; as needed based on service monitoring concerns
Contractor (Agency)	Regional Office	Prior to contract approval or renewal; as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***02 Round the Clock Services***	Sub-Category 1: ***02023 Shared Living, Other***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:** ~~**Host Home**~~ ***Shared Living***

Shared Living is an arrangement in which an individual chooses to live with a couple, another individual, or a family in the community to share their life experiences together. Shared Living can be provided in the home of the care giver (Host Home Services) or in the individual's home (Companion Services).

A Host home ***or Companion*** Home is a private home, licensed or certified by the Division of Developmental Disabilities, where a family or individual accepts the responsibility for caring for up to three individuals with developmental disabilities. Shared Living offers a safe and nurturing home by giving guidance, support and personal attention. The provider plays an active role in the individual's team and the collaborative development of a service plan. The ~~**service**~~ ***support*** plan is based on the team's knowledge of the individual's personal challenges, strengths, skills, preferences and desired outcomes. The ~~**service**~~ ***support*** plan provides guidelines and specific strategies that address the person's needs in the social, behavioral and skill areas and is designed to lead to positive lifestyle changes. Living in a home environment presents daily opportunities to acquire and use new skills. The host family ***or companion*** helps the individual participate in family and community activities and facilitate a relationship with the person and his/her natural family and the general community. They help

the person learn and use community resources and services as well as participate in activities that are valued and appropriate for the person's age, gender and culture. The provider ensures that the person's identified health and medical needs are met and comply with licensure or certification regulations of the Division of Developmental Disabilities.
A single family host ***or companion*** home may be licensed by and directly contract with the DMH, or the host family ***or companion*** may be directly employed by or under contract with an agency licensed by and under contract with DMH to provide host home and/or companion services.
Host Home ***and Companion*** services include the following:
(a) Basic personal care and grooming, including bathing, care of the hair and assistance with clothing;
(b) Assistance with bladder and/or bowel requirements or problems, including helping the individual to and from the bathroom or assisting the individual with bedpan routines;
(c) Assisting the individual with self-medication or provision of medication administration for prescribed medications, and assisting the individual with, or performing health care activities ;
(d) Performing household services essential to the individual's health and comfort in the home (e.g., necessary changing of bed linens or rearranging of furniture to enable the individual to move about more easily in his/her home);
(e) Assessing, monitoring, and supervising the individual to ensure the individual's safety, health, and welfare;
(f) Light cleaning tasks in areas of the home used by the individual;
(g) Preparation of a shopping list appropriate to the individual's dietary needs and financial circumstances, performance of grocery shopping activities as necessary, and preparation of meals;
(h) Personal laundry;
(i) Incidental neighborhood errands as necessary, including accompanying the individual to medical and other appropriate appointments and accompanying the individual for short walks outside the home; and
(j) Skill development to prevent the loss of skills and enhancing skills that are already present that will lead to greater independence and community integration.
Payment to the host ***or companion*** home is a flat monthly rate to meet the individual's support needs, and is exempt from income taxes. The host or companion home will be paid on the basis of intensity and difficulty of care. Methodology is described in Appendix I-2-a of this waiver application.

No more than three individuals receiving host home services may share a residence. Individuals receiving host home services and sharing a home with housemates shall each have a private bedroom, unless they choose otherwise.

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

Parents of minor children, legal guardians, and spouses cannot be providers for their child, ward, or spouse. People who live in a host ***or companion*** home may also receive any other waiver service except for group home, individualized supported living, and personal assistant.
Payments for Host ***or Companion*** Home services do not include room and board, items of comfort or convenience, or the costs of home maintenance, upkeep, and improvement. Persons who receive Host ***or Companion*** Home services shall not also receive state plan personal care or Adult Day ~~**Health**~~ Care.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative	☐	Legal Guardian

Provider Specifications				
Provider	✓	Individual. List types:	✓	Agency. List the types of agencies:

Category(s) *(check one or both)*:	~~**Host Home**~~ ***Shared Living***	~~**Host Home**~~ ***Shared Living***

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
~~**Host Home**~~ ***Shared Living*** (Agency)	Licensed under 9 CSR 40-6.010-6.114,	Certified under 9 CSR 45-5.010-.060.	Accredited through CARF, CQL, or Joint Commission. DMH Contract
~~**Host Home**~~ ***Shared Living*** (Individual)	Licensed under 9 CSR 40-6.010-6.114,	Certified under 9 CSR 45-5.010-.060.	Accredited through CARF, CQL, or Joint Commission. DMH Contract

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
~~**Host Home**~~ ***Shared Living*** (Agency)	Regional Office staff	Prior to contract approval or renewal; as needed basis on service monitoring concerns.
~~**Host Home**~~ ***Shared Living*** (Individual)	Regional Office staff	Prior to contract approval or renewal; as needed basis on service monitoring concerns.

Service Specification	
HCBS Taxonomy	
Category 1: ***04 Day Services***	Sub-Category 1: ***04020 Day Habilitation***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:** ***Day Habilitation*** ~~**Independent Living Skills Development**~~	
Day Habilitation services ~~**Development**~~ focuses on ***fundamental*** skill acquisition/development, retention/maintenance to assist the individual in achieving maximum self-sufficiency. ***Day Habilitation Services assist the individual to acquire, improve and retain the self-help, socialization and adaptive skills necessary to reside successfully in the community. Fundamental skills are a foundation for further learning,***	

such as etiquette in a public setting, recognition of money, proper clothing attire for the time and setting, answering phone, etc. ~~**This service assists the participant to acquire, improve and retain the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings**~~. ***Examples of Day Habilitation Services include, but are not limited to, utilizing etiquette skills at a restaurant, checking out a book at a library, mailing a letter, exchanging money for purchases, etc, This should not only occur in the facility, but on a regular basis in the community to use in a real life situations.*** ~~**Independent Living Skills Development**~~ ***Day Habilitation*** Service differs from the Personal Assistant service in that a personal assistant may directly perform activities or may support the individual to learn how to perform ADLS and IADLS as part of the service. ***Day Habilitation Services includes all personal assistance needed by the individual.*** Individuals who receive Group Home or Individualized Supported Living, or ~~**Host Home**~~ ***Shared Living*** may receive this service; their group home or ISL budget will clearly document no duplication in service.

This service does not provide basic child care (a.k.a. "baby sitting"). When services are provided to children the ISP must clearly document that services are medically necessary to support and promote the development of independent living skills of the child or youth, and are over and above those provided to a child without disabilities. The ISP must document how the service will be used to reinforce skills or lessons taught in school, therapy or other settings and neither duplicates or supplants the services provided in school, therapy or other settings. The ISP must also clearly document the service is not supplanting the responsibilities of the primary caregiver. ISPs ~~**are developed in accordance with Division Directive 4.060 and**~~ must include outcomes and action steps individualized to what the participant wishes to accomplish, learn and/or change. The Utilization Review Committee, authorized under 9 CSR 45-2.017 has the responsibility to ensure all services authorized are necessary based on the needs of the individual and ensures that ~~**Independent Living Skills Development**~~ Day Habilitation services is not utilized in lieu of basic child care that would be provided to children without disabilities.

Day Habilitation services are provided at a stand-alone licensed or certified day program facility, which is not physically connected to the participant's residence. ~~**Day services assist the participant to acquire, improve and retain the self-help, socialization, adaptive, and life skills necessary at home or in the community.**~~ Costs for transporting the participant from their place of residence to the day program site are not included in the day service rate, and waiver transportation may be provided and separately billed.

Medical Exception
Exceptional medical supports funding shall be utilized to provide enhanced services to meet medical needs which require licensed oversight and/or delegation to Certified Nursing Assistance (CNA) for direct prescribed services to identified individuals. A separate rate and code modifier is available for this service. This is to promote individuals ability to access community based services and integration to the fullest extent of their capabilities.
Requests for Exceptional medical supports shall be submitted to the Utilization Review Committee and include the following documentation:

- ***Written Support Plan which includes clinical outcome data with criteria for reduction of supports as relevant to the identified medical condition(s).***
- ***Written documentation noting the individual's assessed need for medical services by the individual's medical practitioner.***

Behavior Exception
Exceptional behavioral supports funding shall be utilized to provide enhanced services to meet behavioral needs which require licensed oversight and/or delegation for direct prescribed services to identified individuals. A separate rate and code modifier is available for this service. This is to promote individuals ability to access community based services and integration to the fullest extent of their capabilities. Requests for Exceptional behavior supports shall be submitted to the Utilization Review Committee and include the following documentation:

- ***Written Support Plan which includes clinical outcome data with criteria for reduction of supports as relevant to the identified target behavior(s).***
- ***Written documentation noting the individual's assessed need for behavioral services by the individual's Board Certified Behavior Analyst or Qualified Health Care Professional.***

~~**This service has three distinct components; each component is listed separately in Appendix J. A provider is not required to make services available in a stand-alone facility to provide this service, but may choose only to provide the Home Skills Development and Community Integration components of this service.**~~

~~**Home Skills Development includes but is not limited to cooking, personal care, house cleaning, and laundry. The service assists the participant to acquire, improve and retain the self-help, socialization, adaptive, and life skills necessary at home. Home Skills development takes place in the participant's residence, including group homes, the individual's private home where they may or may not have unrelated housemates, or in the home of a family member with whom the participant resides. Services may be provided on an individual basis or for groups up to 6.**~~

~~**Community Integration teaches all skills needed to be part of a community, such as using public transportation, making and keeping medical appointments, attending social events, any form of recreation, volunteering, participating in organized worship or spiritual activities. Transportation costs related to the provision of this service in the community are included in the service rate.**~~

~~**A waiver participant's ISP may include any combination of services, but service documentation according to 13 CSR 70-3.030(2)(A) 6. requiring a begin and end time for services reimbursed according to time spent in service delivery will clearly show no duplication or overlap in the time of the day the service is provided, and the place of service must match the billing code.**~~

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

~~**Home skills development may not be provided to any waiver participant who also receives host home supports, as the host home provider is responsible for teaching home skills.**~~ Individuals who ~~**live with host families**~~ receive ***Shared Living services*** may also receive ***day habilitation*** ~~**program**~~ and/or community integration.

A waiver participant's ISP may include any combination of services, but service documentation according to 13 CSR 70-3.030(2)(A)6 requiring a begin and end time for services reimbursed according to time spent in service delivery will clearly show no duplication or overlap in the time of the day the service is provided, and the place of service must match the billing code.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
			~~**Independent Living Skills Program**~~ Day Habilitation	

State:	
Effective Date	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
~~Independent Living Skills Program~~ Day Habilitation	9 CSR 40-1,2,9	9 CSR 45-5.010 certification; CARF, CQL or The Joint Commission	DMH Contract; Direct contact staff must have: A high school diploma or its equivalent; training in CPR and First Aid; and one-year experience working with people with **~~mental retardation~~**/intellectual/developmental disabilities, or in lieu of experience, must successfully complete a Quality Outcome training program approved by the Division of DD regional office. Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administration training must be updated every two years with successful completion. ***Medical and Behavioral Exception for Day Habilitation requires licensed oversight and/or delegation to Certified Nursing Assistance (CNA).***

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
~~Independent Living Skills Program~~ Day Habilitation	**Regional Office**	**Prior to contract approval and ~~renewal~~ every three years; as needed based on service monitoring concerns**

Service Specification	
HCBS Taxonomy	
Category 1: ***04 Day Services***	Sub-Category 1: ***04070 Community Integration***
Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:** ***Community Integration***

Community Integration assists and/or teaches participation in community activities. Community Integration does not include assistance with activities of daily living, unless it is combined with a community integration activity. These activities and/or skills are needed to be a participating member of a community, which may include, but not limited to, becoming a member of social events/clubs, recreational activities, volunteering, participating in organized worship or spiritual activities. The following are examples of activities of daily living that are not included in community integration: grocery/clothing shopping, haircut, etc. Community Integration expectations are for individuals to interact with the broader community on a regular basis, including community activities that enable individuals to engage directly, throughout the day, with people who are not paid to provide them with services. In addition, community activities should be organized for the benefit of the individuals to foster relationships with the broader community. Transportation costs related to the provision of this service in the community are included in the service rate.

A waiver participant's ISP may include any combination of services, but service documentation according to 13 CSR 70-3.030(2) (A) 6. requiring a begin and end time for services reimbursed according to time spent in service delivery will clearly show no duplication or overlap in the time of the day the service is provided, and the place of service must match the billing code.

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

This service is a short term service that is not anticipated to be an ongoing support for individuals. This service is limited to 25 hours a week. Group community integration may not have more than 4 individuals in a group.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Day Habilitation

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Day Habilitation	**9 CSR 40-1,2,9**	**9 CSR 45-5.010 certification; CARF, CQL or The Joint Commission**	**DMH Contract;** **Direct contact staff must have:** **A high school diploma or its equivalent; training in CPR and First Aid; and one-year experience working with people**

			with intellectual/developmental disabilities, or in lieu of experience, must successfully complete a Quality Outcome training program approved by the Division of DD regional office. **Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administration training must be updated every two years with successful completion.**

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Day Habilitation	**Regional Office**	**Prior to contract approval and every three years; as needed based on service monitoring concerns**

Service Specification	
HCBS Taxonomy	
Category 1: ***04 Day Service***	Sub-Category 1: ***04020 Day Habilitation***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:** ***Individualized Skill Development***	
Individualized Skill Development focuses on complex skill acquisition/development, to assist the individual in achieving maximum independence in home and community-based settings. This includes, but is not limited to, cooking, laundry, shopping, budgeting, paying bills, and accessing public transportation. The service assists the participant to acquire life skills necessary for independent living. When applicable, this should be completed in the community. Transportation costs related to the provision of this service in the community are included in the service rate. Individualized Skill Development differs from the Personal Assistant service in that a personal assistant may directly perform activities or may support the individual to	

perform ADLS and IADLS as part of the service.

ISPs must include outcomes and action steps individualized to what the participant wishes to accomplish, learn and/or change, which includes a task analysis of the identified learning objective. The Utilization Review Committee, authorized under 9 CSR 45-2.017 has the responsibility to ensure all services authorized are necessary based on the needs of the individual.

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

Individuals who receive Group Home, Individualized Supported Living, or Shared Living may not receive this service, because it is encapsulated within these aforementioned services and would cause duplication. A person who receives these services may receive Day Habilitation, but may not receive Individualized Skill Development at the Day Habilitation location.

This service is a short term service that is not anticipated to be an ongoing support for individuals as it is utilized for the development of a clearly identified skill. Each skill will require an identified objective, with a task analysis and data of progress. No more than 20 hours a week shall be authorized annually. Group individualized skill development may not have more than 4 individuals in a group.

When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. This service may not be provided by a family member or guardian.
A national/state credentialed staff trained in skill development will be required.

Payment is on a 15 minute, fee for service basis.

A waiver participant's ISP may include any combination of services, but service documentation according to 13 CSR 70-3.030(2)(A) 6. requiring a begin and end time for services reimbursed according to time spent in service delivery will clearly show no duplication or overlap in the time of the day the service is provided, and the place of service must match the billing code.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
			Day Habilitation	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Day Habilitation	**9 CSR 40-1,2,9**	**9 CSR 45-5.010 certification; CARF, CQL or The Joint**	**DMH Contract;** **Direct contact staff must have:**

		Commission	**A high school diploma or its equivalent; training in CPR and First Aid; and one-year experience working with people with intellectual/developmental disabilities, or in lieu of experience, must successfully complete a Quality Outcome training program approved by the Division of DD regional office.** **Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administration training must be updated every two years with successful completion.**

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Day Habilitation	**Regional Office**	**Prior to contract approval and every three years; as needed based on service monitoring concerns**

Service Specification	
HCBS Taxonomy	
Category 1: ***03 Supported Employment***	Sub-Category 1: ***03030 Career Planning***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:** ***Career Planning*** ~~**Job Discovery**~~	
Career planning is a person-centered, comprehensive employment planning and support service that provides one-to-one assistance for waiver program participants to enter into, or advance, in competitive employment or self-employment. It is a focused, time limited service engaging a participant in identifying a career	

direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this service is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

- ***Career Planning services includes activities that are primarily directed at assisting an individual with identification of an employment goal and the plan to achieve this goal (e.g., job exploration, job shadowing, informational interviewing, assessment of interests, labor market research) that are associated with performing competitive work in community integrated employment.***

- ***If a waiver participant is employed, career planning may be used to explore other competitive employment career objectives which are more consistent with the person's skills and interests or to explore advancement opportunities in his or her chosen career.***

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

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

- ***Career planning may include social security benefits support, training and planning.***

- ***Individuals who receive career planning services may also receive supported employment, pre-vocational and/or day habilitation services. A participant's person-centered services and supports plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.***

- ***Services must be provided in a community setting or at a licensed, certified or accredited facility of a qualified employment service provider. The setting for the delivery of services must be aligned with the individualized need and that which is most conducive in developing a career objective and a career plan. Services cannot be provided within an individual's residence.***

Transportation costs for Career Planning services are included in the unit rate, but costs for transporting to and from the residence are not included.

~~**Job discovery services include but are not limited to the following: Volunteerism, self-determination and self-advocacy (assisting an individual in identifying wants and needs for supports and in developing a plan for achieving integrated employment), job exploration, job shadowing, informational interviewing, labor market research, job and task analysis activities, employment preparation (i.e. resume development, work procedures), and business plan development for self-employment. Job discovery is intended to be time-limited. The initial discovery process should not exceed a three month period and will result in the development of a career profile and employment goal or career plan. Additional monthly increments must be preauthorized by the Division of DD.**~~

~~**If it becomes clear that competitive integrated employment is not a reasonable goal and the individual does not plan to move forward toward competitive integrated employment then other supports and services which are designed to continue on a long term basis should be considered.**~~
~~**The waiver will not cover vocational rehabilitation services, which are otherwise available under section**~~

~~**110 of the Rehabilitation Act of 1973. Therefore, the case records for individuals receiving job discovery and preparation services under the waiver will document that the participant was denied benefits by the Missouri Department of Elementary and Secondary Education, Office of Adult Learning and Rehabilitation Service (VR), exhausted VR benefits (nine months is the maximum in Missouri), VR does not cover the specific employment service the individual requires, or the person requests supports from a provider that does not participate in VR's system. The service coordinator's documentation of VR's failure to confirm a denial of benefits in writing within 30 days of verbal notification may also serve as evidence of eligibility for job discovery and preparation services.**~~

~~**When participants are compensated they must be paid in accordance with the United States Fair Labor Standards Act (USFLSA) of 1985.**~~

~~**Services may be provided in a community workplace setting or at a licensed, certified or accredited facility of a qualified job discovery and preparation service provider.**~~

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

Career Planning ~~**Job Discovery**~~ is intended to be time-limited***. Services should be authorized through person centered employment planning based upon individualized assessed need not to exceed 240 quarter hour units of services within an annual support plan. Additional units may be approved by the Division's Regional Director or designee in exceptional circumstances.***
~~**The initial discovery process should not exceed a three month period and will result in the development of a career profile and employment goal or career plan.**~~

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Employment Services ~~**Community Employment**~~ Provider
				~~**Day Habilitation**~~

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
~~**Community**~~ **Employment** ***Services*** **Provider**	~~**9 CSR 30-5.050**~~	9 CSR 45-5.010 certification; CARF, CQL or Joint Commission accreditation	DMH Contract
~~**Day Habilitation Provider**~~		~~**Certified by DMH under 9 CSR 45-5.010; Accredited by the CARF in the area of Personal,**~~	~~**DMH Contract**~~

		~~**Social and Community Services; or accredited by CQL or Joint Commission**~~	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
~~**Community**~~ Employment ***Service*** Provider	Regional Office	Prior to contract approval ~~**or renewal**~~ and every three years; as needed based on service monitoring concerns
~~**Day Habilitation Provider**~~	~~**Regional Office**~~	~~**Prior to contract approval or renewal; as needed based on service monitoring concern**~~

Service Specification	
HCBS Taxonomy	
Category 1: ***11 Other Health and Therapeutic Services***	Sub-Category 1: ***11080 Occupational Therapy***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**: Occupational Therapy**	
Occupational therapy requires prescription by a physician and evaluation by a certified occupational therapist (OT) or certified occupational therapeutic assistant (COTA) under the supervision of an OT. The service includes evaluation, plan development, direct therapy, consultation and training of caretakers and others who work with the individual. It may also include therapeutic activities carried out by others under the direction of an OT or COTA . Examples are using adaptive equipment, proper positioning and therapeutic exercises in a variety of settings. Occupational therapy is covered under the Medicaid state plan for children and youth under the age of 21, so waiver OT is only for people age 21 and over.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Occupational therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Occupational therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first for persons before DD waiver occupational therapy is provided.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Occupational Therapist		Agency employing licensed Occupational Therapists and may also employ registered COTA's supervised by licensed Occupational Therapists	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Occupational Therapist		Certified per RSMo 1990 334.735—334.746 as Occupational Therapist by AOTA or registered as a COTA	DMH Contract; Occupational therapist must be either certified as an occupational therapist by the American Occupational Therapy Association or registered as a Certified Occupational Therapeutic Assistant (COTA). Requirements for registration as a COTA in Missouri are: Attainment of a two-year associate degree from an accredited college; successful completion of a state exam; and registration with the State Division of Professional Registration. In addition, COTAs must receive supervision from a professional OT on a periodic, routine and regular basis.
Agency employing licensed Occupational Therapists and may also employ registered COTA's supervised by licensed Occupational		Certified per RSMo 1990 334.735—334.746 as Occupational Therapist by AOTA or registered as a COTA	DMH Contract; Occupational therapist must be either certified as an occupational therapist by the American Occupational Therapy Association or registered as a Certified Occupational Therapeutic Assistant (COTA). Requirements for registration as a COTA in Missouri are: Attainment of a two-year associate degree from an accredited college; successful completion of a state exam; and registration with the State Division of Professional Registration. In addition, COTAs must receive supervision from a professional OT

Therapists			on a periodic, routine and regular basis.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Occupational Therapist	Regional Office	Prior to contract approval or renewal; as needed based on service monitoring concerns
Agency employing licensed Occupational Therapists and may also employ registered COTA's supervised by licensed Occupational Therapists	Regional Office	Prior to contract approval or renewal; as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***09 Care Giver Support***	Sub-Category 1: ***09011 Respite, Out of Home***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**: Out of Home Respite**	
Out of home respite is care provided outside the home in a licensed, accredited or certified waiver residential facility, ICF/~~**MR**~~ ***ID*** or State Habilitation Center by trained and qualified personnel for a period of no more than 60 days per year. The need for this service has to be an identified need through the planning process which would include the individual, guardian if applicable, the primary caregiver, other family members, Support coordinator, and any other parties the individual requests. The purpose of respite care is to provide planned relief to the customary caregiver and is not intended to be permanent placement. FFP is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Out of home respite is limited to no more than 60 days annually, ***unless a written exception is granted from the Regional Office Director***.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Community Residential Facility
				State-operated ICF/~~**MR**~~ ***ID***

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community Residential Facility	9 CSR 40-1,2,4,5	9 CSR 45-5.010; CARF; CQL; or Joint Commission	DMH Contract
State-operated ICF/~~**MR**~~ ***ID***		13 CSR 15-9.010	In good standing with DHSS

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community Residential Facility	Regional Office	Prior to contract approval; service review every 3 years; as needed based on service monitoring concerns
State-operated ICF/~~**MR**~~ ***ID***	DHSS ICF/ID Unit	Annual

Service Specification	
HCBS Taxonomy	
Category 1: ***17 Other Services***	Sub-Category 1: ***17990 Other***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:

State:	
Effective Date	

Category 4:	Sub-Category 4:

Service Definition (Scope)**: Person Centered Strategies Consultation**

This service involves consultation to the individual's support team to improve the quality of life for the individual through the development of and implementation of positive, proactive and preventative, Person Centered Strategies and a modified environment and/or life style for the individual. Person Centered Strategies consultation involves evaluating a person's setting, schedule, typical daily activities, relationships with others that make up the supports for an individual including paid staff/paid family and unpaid natural supports. The evaluation leads to changes in strategies including such things as re-arranging the home to reduce noise and stimulation, adding a personal quiet area to allow the individual to get away from annoying events, teaching skills to promote more positive interactions between the individual and supporting staff or family. Evaluation may involve identifying skills that would help the individual to have a better quality of life and assist the support staff/family to teach these meaningful skills to the individual and identify ways to proactively prevent problem situations and assisting the individual and support staff/family to use these new strategies and problem solving techniques for the individual. Such strategies developed could include: clarifying the expectations for the individual and all members of the support team, and establishing positive expectations or rules for the individual with the support team learning to change their system to support in these more positive ways, improving recognition of desirable actions and reduction of problematic interactions that might evoke undesirable responses from the individual. A large part of the consultation will involve assisting the support system to develop a sustainable implementation plan and to insure a high fidelity of implementation and consistency of use of the strategies to assist and support the individual. ***This is not a direct therapy type service, for example the consultant's interaction with the individual should be pleasant and positive, but it is not this interaction that improves the quality of the person's life, rather the changes made to the person's support system, especially those focusing on implementation of identified strategies make the difference for the individual.***

Person Centered Strategy consultation might work towards improved quality of life for the individual through training of support persons and developing a way for the support system to monitor and evaluate the interactions and systems to establish increased opportunities for teaching and practice of necessary skills by the individual, increasing recognition of desirable actions by the individual and the support team, increased frequency and types of positive interactions by support persons with and by the individual, and assisting the individual and support team to arrange practice opportunities such as social skills training groups or arranging a system of coaching and prompting for desirable actions in situations that commonly are associated with problems. The consultant might establish and lead such practice opportunities while coaching support person to continue the practice when the service is discontinued.

The unit of service is one-fourth hour. This is a short term service that is not meant to be on going, the typical duration of service is to be twelve months or less.

This service is not to be provided for development or implementation of behavior support plans or functional assessment as these services require licensure as a behavior analyst, psychologist, counselor or social worker with specialized training in behavior analysis. However, this service might work in conjunction with a behavior analysis service provider to develop and establish a support system that can implement strategies towards a good quality of life for the individual.

Person Centered Strategies Consultation differs from the Behavior Analysis Service in that PCSC the focus and whole scope of the service is on identifying barriers to a good quality of life and improving proactive, preventative and teaching based strategies to increase desirable, healthy skills and thus reduce problem situations. In addition, the PCSC will require providers with a less involved level of training and experience than

BAS.

Outcomes expected for this service are as follows:
1. Written document describing the results of the evaluation of the system to identify problem situations, strategies and practices and relate these to the quality of life for the focus individual.
2. Summary of recommended strategies developed with the support team to address the identified problems and practices based on the evaluation.
3. Training for the individual and support team to implement the strategies with fidelity and collect data to determine effectiveness of the strategies that will assist the individual in achieving a good quality of life.
4. A written document that is incorporated into the Individual Support Plan to insure the implementation of the new strategies with fidelity and consistency by the support team after the PCSC is completed.

Documentation for the service:
1. Identification of the outcome being addressed during the service unit(s) for a particular session.
2. Description of progress towards the outcome.
3. Actions steps and planning for the next service sessions including a timeline and steps necessary to achieve the outcome.

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

This is a short term service that is not meant to be on going, the typical duration of service is to be twelve months or less.

Psychology/Counseling services under EPSDT do not include Person Centered Strategies services.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Person Centered Strategies Consultant		Agency employing a Person Centered Strategies Consultant	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency employing a Person Centered Strategies Consultant			An agency or an individual must have a DMH contract. This service can be provided by an Individual or an agency who is a Qualified Person Centered Strategies Consultant. A Person Centered Strategies Consultant is a person with a bachelor's degree with special training, approved by the Division,

			related to the theory and practice of Person Centered Strategies for individuals with intellectual and developmental disabilities, or Applied Behavior Analysis and implementation of Person Centered Approaches. Training will be approved by Division of DD staff if the training syllabus describes positive, proactive intervention strategies, quality of life variables and evaluation and improvement strategies and system wide implementation of evidence based practices. This includes for example: The Tools of Choice Training with additional coaching of tools training; College course work for example within a special education department involving implementation of Tiered Supports strategies; training from a state agency on implementation of tiered supports and person centered strategies and quality of life.
Person Centered Strategies Consultant			An agency or an individual must have a DMH contract. This service can be provided by an Individual or an agency who is a Qualified Person Centered Strategies Consultant. A Person Centered Strategies Consultant is a person with a bachelor's degree with special training, approved by the Division, related to the theory and practice of Person Centered Strategies for individuals with intellectual and developmental disabilities, or Applied Behavior Analysis and implementation of Person Centered Approaches. Training will be approved by Division of DD staff if the training syllabus describes positive, proactive intervention strategies, quality of life variables and evaluation and improvement strategies and system wide implementation of evidence based practices. This includes for example: The Tools of Choice Training with additional coaching of tools training; College course work for example within a special education department involving

			implementation of Tiered Supports strategies; training from a state agency on implementation of tiered supports and person centered strategies and quality of life.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agency employing a Person Centered Strategies Consultant	Regional office	Prior to contract approval ~~**or renewal**~~**;** as needed based on service monitoring concerns
Person Centered Strategies Consultant	Regional office	Prior to contract approval ~~**or renewal**~~; as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***11 Other Health and Therapeutic Services***	Sub-Category 1: ***11090 Physical Therapy***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**: Physical Therapy**

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

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

Services may include ***clinical*** consultation provided to ***individuals, parents, primary caregivers***, ~~**families**~~ and ~~**caretakers**~~ ***other programs*** or habilitation services providers. . ~~**Physical therapy services may not be carried out by a paraprofessional.**~~ A unit of service is 1/4 hour.

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Physical therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Physical therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first before the waiver physical therapy is provided. Children have access to EPSDT services

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Physical Therapist			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Physical Therapist	Licensed per RSMo 1990 334.530--334.625		DMH Contract

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Physical Therapist	**Regional office**	**Prior to contract approval or renewal; as needed based on service monitoring concerns**

Service Specification

HCBS Taxonomy	
Category 1: ***11 Other Health and Therapeutic Services***	Sub-Category 1: ***11010 Health Monitoring***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition (Scope)**: Professional Assessment and Monitoring**

Professional Assessment and Monitoring (PAM) is intended to promote and support an optimal level of health and wellbeing. PAM is a consultative service by a licensed health care professional that may include assessment, examine, evaluate, and/or treat an individual of identified condition(s) or healthcare needs and planning to include instructions and training for caregivers when indicated. PAM services maintain, restore and / or improve an individual's functional status. PAM may include ancillary, management and / or instructional strategies.

PAM providers are to coordinate and communicate with the individual, their caregivers and the support team. This would include but is not limited to reporting all changes in health status to the physician and the support coordinator and providing written reports of the visit to the support coordinator. All services must be documented in the individual record.

~~**A face to face visit to evaluate need and identify appropriate assistance including any special instructions for participants and their caregivers to reduce the need for routine health professional visits and prevent a higher level of care, which may include limited physical assessments, medication set up, injections, limited diagnosis and treatment, nutritional care plans, nutritional counseling if the nutritional problem or condition is of such a degree of severity that counseling is beyond that normally expected as a part of standard medical management, and nutritional therapy services, not otherwise covered by Medicare or Medicaid state plan services.**~~

Any changes in health status are to be reported to the physician and Support coordinator as needed. Written reports of the visit are required to be sent to the Support coordinator. This service may be provided by a licensed registered professional nurse, or a licensed practical nurse under the supervision of a registered nurse, or a licensed dietitian to the extent allowed by their respective scope of practice in the State of Missouri.

This service must not supplant Medicaid State plan services or Medicare services for which an individual is eligible. Excluded services include Diabetes Self Management Training available under the state plan and medical nutrition therapy services prescribed by a physician for Medicare eligibles who have diabetes or renal diseases.

Professional Assessment and Monitoring service providers must have a valid DMH contract and/or provide services through an Organized Health Care Delivery system for the provision of Professional Assessment and Monitoring services.

Service Documentation:

Providers of Professional Assessment and Monitoring must maintain an individualized plan of treatment and detailed record of intervention activities by unit of service. The provider is required to follow procedures set forth under The Code of State Regulations 13 CSR 70-3.030, which defines adequate documentation.

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

The contractor shall not be the consumer's spouse, a parent of a minor child (under age 18), nor a legal guardian.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	✓	Individual. List types:	☐	Agency. List the types of agencies:
	Professional Nurse or Dietician.			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Professional Nurse or Dietician.	Licensed per RsMo Chapter 335., 20 CSR 2200-4.020 in Missouri as a Registered Nurse (RN), Licensed Practical Nurse (LPN), or licensed per RsMo 324.200-324.4.225, 20 CSR 2115-2.020 Dietician		DMH Contract

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Professional Nurse or Dietician.	Regional Office	Prior to initial contract and ~~annually~~ **renewal; as needed based on service monitoring concerns**

Service Specification	
HCBS Taxonomy	
Category 1: ***14 Equipment, Technology, and Modification***	Sub-Category 1: ***14031 Equipment and Technology***
Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**: Specialized Medical Equipment and Supplies (Adaptive Equipment)**

Specialized medical equipment and supplies includes devices, controls, or appliances, specified in the ~~**service**~~ ***support*** plan, which enable ~~**recipient**~~ ***individuals*** to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, durable and non-durable medical equipment and supplies, and equipment repairs when the equipment, supplies and repairs are not covered under the Medicaid State DME plan. Includes incontinence supplies.

Items reimbursed with waiver funds, shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. All items shall meet applicable standards of manufacture, design and installation.

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

Costs are limited to $7,500 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.

Other specialized equipment, supplies and equipment repair needs for the eligible person that can be met through state plan, including EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. DD waiver other specialized equipment, supplies and repairs shall be provided above and beyond any state plan, including EPSDT, equipment, supplies, and repair service that can meet the individual's needs. Further, this waiver service may also be authorized for items/repairs not covered under state plan and falls within the waiver service definition described above.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Medical Equipment & Supply

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Medical Equipment &			Registered and in good standing with Missouri Secretary of State; DMH

Supply			Contract; must be enrolled with Medicaid as a state plan Durable Medical Equipment Provider.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Medical Equipment & Supply	Regional Office	Prior to contract approval ~~**or renewal; service review every 2 years**~~**;** as needed based on service monitoring **concerns**

Service Specification	
HCBS Taxonomy	
Category 1: ***11 Other Health and Therapeutic Services***	Sub-Category 1: ***11100 Speech, Hearing, and Language Therapy***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**: Speech Therapy**

Speech Therapy is for individuals who have speech, language or hearing impairments. Services may be provided by a licensed speech language therapist or by a provisionally licensed speech therapist working with supervision from of a licensed speech language therapist. The individual's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. The need for services must be identified in the ***support*** plan ~~**of care**~~ and prescribed by a physician. Speech therapy provides treatment for delayed speech, stuttering, spastic speech, aphasic disorders, and hearing disabilities requiring specialized auditory training, lip reading, signing or use of a hearing aid.

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

Waiver providers must be licensed by the State of Missouri as a Speech Therapist. The Medicaid Waiver enrolled provider may employ a person who holds a provisional license from the State of Missouri to practice speech-language pathology or audiology. Persons in their clinical fellowship may be issued a provisional license. Clinical fellowship is defined as the supervised professional employment period following completion of the academic and practicum requirements of an accredited training program. Provisional licenses

are issued for one year. Within 12 months of issuance, the applicant must pass an exam promulgated or approved by the board and must complete the master's or doctoral degree from an institution accredited by the Council on Academic Accreditation of the American Speech-Language-Hearing Association in the area in which licensing is sought. Provisionally licensed speech therapists must receive periodic, routine supervision from their employer, a Medicaid waiver enrolled speech therapy provider.

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

.

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

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

Speech therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Speech therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first for persons before DD waiver speech therapy is provided.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	✓	Individual. List types:	☐	Agency. List the types of agencies:
	Licensed Speech Therapist			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Speech Therapist	Licensed per RSMo 1990 345.050	Provisionally licensed per RSMo 1998 345.022, employed & supervised by licensed speech therapist	DMH Contract

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Licensed Speech Therapist	Regional Office	Prior to contract approval or renewal; ~~**service review every**~~

		~~**2 years;**~~ as needed based on service monitoring concerns

Service Specification	
HCBS Taxonomy	
Category 1: ***12 Services Supporting Self Direction***	Sub-Category 1: ***12020 Information and Assistance in Support of Self-Direction***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**: Support Broker**

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

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

A Support Broker provides the individual or designated representative with information and assistance to:

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

Support brokers must have a background screening per the Division of DD, be at least 18 years of age and possess a high school diploma or GED.

The support broker must have experience or Division DD approved training in the following areas:

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

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

.

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

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

A Support Broker may not be a parent, guardian or other family member. They cannot serve as a personal assistant or perform any other waivered service for that individual. This service can be authorized for up to 8 hours per day (32 quarter hour units).

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
	~~**Individual Support Broker**~~		Individualized Supported Living or Day Habilitation	
			State Plan Personal Care Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
~~**Individual Support Broker**~~			~~**Individual Support Broker who is Age 18: meets minimum training requirements; agreement with Division Regional Office; agreement with individual/designated representivie, supervised by individual/designated representative;**~~ ~~**DMH Contract**~~
Individualized Supported Living or Day Habilitation		DMH Certification for ISL or day hab; or CARF/CQL/Joint Commission	DMH Contract; employs qualified support brokers

		accredited for ISL or day hab	
State Plan Personal Care Provider			***DMH Contract; MO HealthNet Personal Care Enrollment***

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
~~**Individual Support Broker**~~	~~**Regional Office and Individual/Family**~~	~~**Prior to contract approval or renewal; as needed based on service monitoring concerns.**~~
Individualized Supported Living or Day Habilitation	Regional Office	Prior to contract approval ~~**or renewal**~~; as needed based on service monitoring concerns
State Plan Personal Care Provider	***Regional Office***	***Prior to contract approval; as needed based on service monitoring concerns***

Service Specification	
HCBS Taxonomy	
Category 1: ***15 Non-Medical Transportation***	Sub-Category 1: ***15010 Non-Medical Transportation***
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**: Transportation**

Transportation is reimbursable when necessary for an individual to access waiver and other community services, activities and resources specified by the service plan. Transportation under the waiver shall not supplant transportation provided to providers of medical services under the state plan as required by 42 CFR 431.53, nor shall it replace emergency medical transportation as defined at 42 CFR 440.170(a) and provided under the state plan. State plan transportation in Missouri is provided to medical services covered under the state plan, but not to waivered services, which are not covered under the state plan. Transportation is a cost effective and necessary part of the package of community services, which prevent institutionalization.

A variety of modes of transportation may be provided, depending on the needs of the individual and availability of services. Alternatives to formal paid support will always be used whenever possible. A unit is one per month.

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

State plan transportation under this waiver is limited to medical services covered in the state plan. State plan transportation does not cover transporting persons to waiver services, which are not covered under the state plan.

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
			Transportation Agency	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Transportation Agency	RSMo., Chapter 302, Drivers & Commercial Licensing		DMH Contract

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Transportation Agency	Regional Office	Prior to contract approval ~~**or renewal; service review every 2 years;**~~ as needed based on service monitoring concerns

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 C-1-c)*
	☐	As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*
	✓	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
	☐	As an administrative activity. *Complete item C-1-c.*

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

Division of DD Regional Offices (State Employees) and approved Targeted Case Management Entities Employees

Appendix C-2: General Service Specifications

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)*:

✓	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	(a) Background screening is required for all provider staff and volunteers who have contact with consumers. Background screenings are required for volunteers who are recruited as part of an agency's formal volunteer program. It does not apply to volunteers who assist individuals as a friend would by providing assistance with shopping, transportation, recreation, etc. Background screenings are also required for members of the provider's household who have contact with residents or consumers, except for minor children. (Title 9 Code of State Regulations 10.5.190 and Department Operating Regulation 6.510). (b) An inquiry must be made for all new employees and volunteers with the Missouri Department of Health and Senior Services to determine whether the new employee or volunteer is on Department of Social Services or the Department of Health and Senior Services disqualification list. An inquiry is also made with the Department of Mental Health to determine whether the individual is on the DMH disqualification registry. A criminal background check with the Missouri State Highway Patrol is required. The criminal background check and inquiries are initiated prior to the employee or volunteer having contact with residents, clients, or patients. All new applicants for employment or volunteer positions involving contact with residents or clients must: 1) sign a consent form authorizing a criminal record review with the Missouri State Highway Patrol either directly through the patrol or through a private investigatory agency; 2) disclose his/her criminal history including any conviction or a plea of guilty to a misdemeanor or felony charges and any suspended imposition of sentence, any suspended execution of sentence, or any period of probation or parole; and 3) disclose if he/she is listed on the employee disqualification list of the Departments of Social Services, Health and Senior Services, or Mental Health. (c)Employers are responsible for requesting the background screenings. A single request is used and submitted to the state's Family Care Safety Registry, operated by the Department of Health and Senior Services. The Family Care Safety Registry has access to the criminal record system of the state Highway Patrol as well the abuse/neglect and employee disqualification lists/registries that are required. (d) Each agency must develop policies and procedures regarding the implementation of this rule and the disposition of information provided by the criminal record review. Review of provider policies and procedures are part of a provider licensure/certification site visit per 9 CSR 40-2.075. The DMH licensure/certification process, Division of DD Provider Relations review, and Division of DD Fiscal Review process all look for evidence that background investigations are completed as required

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

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

✓	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	(a) The Department of Mental Health (DMH) maintains the Disqualification Registry which is a list of individuals disqualified from working with consumers receiving services from the department. Statutory authority is contained in RSMo 630.170. The Department of Health and Senior Services also maintains an employee disqualification list. (b) All new applicants for employment or volunteer positions involving contact with consumers or residents are checked against the Department of Mental Health's Disqualification Register and the Department of Health and Senior Services' Disqualification List. (c) Surveys for licensing and certifying community residential facilities and day programs ensure these providers have records to support staff and volunteers have been properly screened. Local Regional Office quality enhancement staff or Department audit services staff review records while conducting other reviews or based on reports that screenings are not being completed. (d)Employers are responsible for requesting the background screenings. A single request is used and submitted to the state's Family Care Safety Registry, operated by the Department of Health and Senior Services. The Family Care Safety Registry has access to the criminal record system of the state Highway Patrol as well the abuse/neglect and employee disqualification lists/registries that are required.
○	**No**. The State does not conduct abuse registry screening.

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

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
✓	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Semi-Independent Living	Group Home	Clustered Apartment Living where no more

		than 4 individuals live in a single apartment. Clustered apartment residences are no located on a campus on institutional grounds.
Residential Center	Group Home	10 or more. Not located on a campus on institutional grounds.
Group Home	Group Home	Less than 10. Group homes are not located on a campus on institutional grounds.

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Each participant has a ~~**service**~~ ***support*** plan that specifies individual support needs and interests. Facilities must provide home like environments that afford individuals access to typical facilities in a home such as cooking facilities and small dining areas and must provide individuals access to resources and activities in the community consistent with their service plan. Individuals have their own bedrooms or may share a room with one other individual but no more than two other individuals. Larger facilities must have a client rights committee which includes individual rights to privacy. *Support* service coordinators monitor monthly. Periodic reviews are conducted by local quality enhancement staff or when the *Support* service coordinator requests based on monitoring findings. Certification staff reviews the facility every other year. All of these entities/processes measure the environment against the Missouri Quality Outcomes to ensure individuals have home like living arrangements.

Semi-Independent Living facilities are clustered apartments where no more than 4 individuals live in a single apartment**.**

iii. Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following *(check each that applies)*:

Standard	Topic Addressed
Admission policies	✓
Physical environment	✓
Sanitation	✓
Safety	✓
Staff : resident ratios	✓
Staff training and qualifications	✓
Staff supervision	✓
Resident rights	✓
Medication administration	✓
Use of restrictive interventions	✓
Incident reporting	✓
Provision of or arrangement for necessary health services	✓

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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

✓	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-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 specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	Personal assistant services shall not be provided by an individual's spouse, if the individual is a minor (under age 18) by a parent, or legal guardian. Personal assistant services may otherwise be provided to a person by a member(s) of his or her family when the person is not opposed to the family member providing the service and the service to be provided does not primarily benefit the family unit, is not a household task family members expect to share or do for one another when they live in the same household, and otherwise is above and beyond typical activities family members provide for another adult family member without a disability. In case of a paid family member the service plan must reflect: • The individual is not opposed to the family member providing services; • The services to be provided are solely for the individual and not task household tasks expected to be shared with people live in family unit; • The planning team determines the paid family member providing the service best meet the individual's needs; • A family member will only be paid for the hours authorized in the service plan and at no time can these exceed 40 hours per week. Any support provided above this amount would be considered a natural support or the unpaid care that a family member would typically provide;

	• Family members can be hired for personal assistant only. Family is defined as: A family member is defined as a parent, step parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild. Family members approved to provide personal assistant services may be employed by an agency or employed by the individual/guardian or designated representative using an approved fiscal management service provider. If the person employs his/her own workers using an approved fiscal management service provider, the family member serving as a paid personal assistant shall not also be the designated representative/common law employer.
○	**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.** Specify the controls that are employed to ensure that payments are made only for services rendered.
○	Other policy. *Specify*:

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

Interested providers contact the Regional Office in the area where they plan to provide services. Regional Office contract staff determines if the provider meets provider qualifications by reviewing documentation that serves as proof of requirements such as licensing, certification, accreditation, training, appropriate staff, etc. If the provider is qualified, the Regional Office initiates a DMH Waiver contract with the provider and assists the provider with enrolling as an DD Medicaid Waiver provider through the Medicaid agency. All qualified, willing providers are assisted in enrolling as a waiver provider as provided in 42 CFR 431.51. The average time to enroll as a waiver provider is estimated to be 90-days.

Division of DD Directive, 5.060, Enrollment of New Providers, was established to ensure consistent standards are followed by the Division's 11 Regional Offices in enrolling new providers.

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.

i. Performance Measures

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

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

Performance Measure:	***The*** number and percent of ~~**initial provider applications that met enrollment criteria**~~ ***providers paid through the waiver who are licensed, certified, or deemed*** ~~**contracting**~~**.**(***The*** number ***of licensed, certified, or deemed providers paid through the waiver within the identified time period divided by the number of providers billing through the waiver within the identified time period.*** ~~**initial applications meeting requirements prior to providing services over number of all new provider applications**~~)

Data Source *(Select one) (Several options are listed in the on-line application):Provider Performance Monitoring*

If 'Other' is selected, specify:

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

Add another Data Source for this performance measure

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*	~~☐~~ **X** *Quarterly*
☐ *Other Specify:*	~~☐~~ **X** *Annually*
	~~✓~~*Continuously and Ongoing*

State:	
Effective Date	

	☐ *Other Specify:*

Performance Measure:	~~**Number and percent of providers who initially met applicable licensure/ certification/ accreditation requirements. (Number of applying providers that initially met applicable licensure/ certification/accreditation prior to providing services over all newly enrolled provdiers.)**~~
Data Source *(Select one) (Several options are listed in the on-line application):* ~~**Other**~~	
If 'Other' is selected, specify: Provider Performance 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 =*
	☐ *Other Specify:*	☐ *Annually*	
		Continuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *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*
tate Medicaid Agency	☐ *Weekly*
Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other*

State:	
Effective Date	

	Specify:

Performance Measure:	~~*Number and percent of providers who maintained ongoing licensure/certification/ accreditation. (Number of providers that maintained ongoing licensure/certification/ accreditation ÷ number of ongoing providers seeking renewal of licensure/certification/accreditation.)*~~
Data Source *(Select one) (Several options are listed in the on-line application):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*	*00% Review*
	☐*Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	Other Specify: DMH Licensure and Certification Unit	☐ *Annually*	
		ontinuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *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:

Add another Performance measure (button to prompt another performance measure)

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

i. Performance Measures

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

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

Performance Measure:	*Number and percent of non-licensed and non-certified* ***self-directed*** *providers****,*** *meet****ing*** *waiver provider qualifications. (Number of , self directed employees* ***meeting waiver provider qualifications within the sample within the identified quarterdivided byNumber of self-directed employees reviewed within the sample within the identified quarter****.*		
Data Source *(Select one) (Several options are listed in the on-line application):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*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	

State:	
Effective Date	

				✓*Other Specify:**1/3 sample yearly which exceeds .95confidence interval***

Add another Data Source for this performance measure

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:*	~~☐~~ **X** *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	***Number and percent of providers of respite and/or personal assistant meeting Waiver provider qualifications (number of providers of respite and/or personal assistant meeting waiver provider qualifications divided by number of providers reviewed.)***
Data Source *(Select one) (Several options are listed in the on-line application):**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*	***X*** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	***X*** *Representative Sample; Confidence Interval =.95*
	☐ *Other Specify:*	✓*Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*

State:	
Effective Date	

		☐ *Other Specify:*		
				☐ *Other*

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:*

Add another Performance measure (button to prompt another performance measure)

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.***

i. Performance Measures

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

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

Performance Measure:	*Number and percent of* ***personnel records reviewed by Licensure and Certification during the time period identified meeting training requirements.*** ~~***providers meeting provider training requirements.***~~ *(Number of* ***personnel records reviewed by Licensure and Certification during the time period meeting training*** ~~requirementsproviders who met requirements ÷~~ *divided by* ~~**total**~~ *number of* ***personnel records reviewed by Licensure and Certification*** ~~**providers reviewed**~~*)*

Data Source *(Select one) (Several options are listed in the on-line application):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*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	***Number and percent of personnel records reviewed by Provider Relations during the time period identified meeting training requirements. (Number of personnel records reviewed by Provider Relations during the time period meeting training requirements divided by number of personnel records reviewed by Provider Relations)***

Data Source *(Select one) (Several options are listed in the on-line application):* ***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*	
		✓ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			✓ Other Specify: Sample will differ with provider services provided in accordance with Division Policy

Data Aggregation and Analysis

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

Performance Measure:	***Number and percent of providers surveyed by Licensure and Certification within established timelines. (Number of providers surveyed***

	by Licensure and Certification within established timelines, within the time period identified divided by number of providers due for licensure and certification survey within the identified time period.)

Data Source *(Select one) (Several options are listed in the on-line application):* ***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*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	***Number and percent of providers surveyed by Provider Relations within established timelines. (Number of providers surveyed by Provider Relations within established timelines, within the time period identified÷***

	number of providers due for provider relations survey within the identified time period.)

Data Source *(Select one) (Several options are listed in the on-line application):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*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *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:*

Add another Performance measure (button to prompt another performance measure)

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. In addition, provide information on the methods used by the State to document these items.*

(a1, a5, c1): New applicants who do not meet the initial provider enrollment qualifications are not enrolled as providers. Upon successful completion of the provider enrollment process, the provider relations staff notifies the DMH Licensure and Certification (L&C) Unit that the provider is ready to pursue their certification or license, if applicable for the services provided. The L&C Unit conducts a survey to determine if standards for those services are met and produces a written report within 30 business days of the site survey; if standards are met, L&C issues a license or a certificate. If the provider does not meet the standards, they must complete a plan of correction within 30 days of receipt of the written report. The L&C Unit then has 10 working days to accept or reject the plan of correction. Necessity for additional site visit(s) is determined by the type, scope and extent of the issues for improvement, and the L&C Unit, as well as the Provider Relations contact at the Regional Office, follows through on the process. Final determination of conformance to standards results in issuance of the license or certificate, or results in denial of license or certificate. If the license or certificate is denied, the contract is terminated. The Regional Office corrects any authorizations made in error as well as filing adjustments for any claims paid in error and reports the action to the Regional Office quality assurance staff in writing, describing how the error was corrected and any remedial training that was provided to staff.
(a3) Provider Relations staff at the Regional Office determine conformance with qualifications for contract purposes. Provider Relations conducts a review on an annual basis to assure the non-licensed/certified/accredited providers are in compliance with contract requirements.

Providers who do not maintain qualifications are dis-enrolled as providers for waiver services. The Regional Office corrects any authorizations made in error as well as filing adjustments for any claims paid in error and reports the action to the Regional Office quality enhancement staff in writing, describing how the error was corrected and any remedial training that was provided to staff.

(b1) In addition to targeted training all self-directed employees must have background checks completed and be registered with the Family Care Safety Registry (FCSR) before they can be paid for services. If it is determined a worker did not have a background check completed prior to the worker beginning, the Financial Management Service contractor is notified within 10 days of discovery by Regional Office management staff that an error has occurred since the contractor is responsible for background checks. The contractor must respond in writing with 30 days to the Regional Office describing how the error has been corrected. Case management staff will assure the worker does not provide additional services until the check is completed satisfactorily. Administration staff will take action to adjust authorizations made in error and any claims paid in error.

(c1): The L&C Unit conducts a survey to determine if standards are met and produces a written report within 30 business days of the site survey; if standards are met, L&C issues a license or a certificate. If

the provider does not meet the standards, they must complete a plan of correction within 30 days of receipt of the written report. The L&C Unit then has 10 working days to accept or reject the plan of correction. Necessity for additional site visit(s) is determined by the type, scope and extent of the issues for improvement, and the L&C Unit, as well as the Provider Relations contact at the Regional Office, follows through on the process. Final determination of conformance to standards results in issuance of the license or certificate, or results in denial of license or certificate. If the license or certificate is denied, the contract is terminated. The Regional Office corrects any authorizations made in error as well as filing adjustments for any claims paid in error and reports the action to the Regional Office quality assurance staff in writing, describing how the error was corrected and any remedial training that was provided to staff.

Providers accredited by CARF International or Council for Quality and Leadership (CQL) are deemed certified, as outlined in Missouri Code of State Regulation. These accredited providers submit a copy of their most recent accreditation survey and the statement of accreditation to the Division of DD, to verify that the accreditation status is current and to determine what areas of improvement are noted. If an improvement plan is required by the accrediting body, that correspondence is also submitted to the Division. The Division Standards and Accreditation Coordinator tracks to assure that these reports are submitted and reviewed; if the current status is not on file, the Coordinator contacts the Provider Relations staff at the Regional Office to assist in obtaining the required documentation.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
[redacted]	☐ *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-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

○	**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; and, (f) how participants are notified of the amount of the limit.

✓	**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*.
	(a) Environmental Accessibility Adaptations and Specialized Medical Equipment and Supplies have a limit of $7,500 annually; Assistive Technology is limited to **~~$3,000~~** ***9,000*** annually; and Community Transition has a lifetime limit of $3,000. Limits were set to ensure only a level of service necessary to avoid entering an institution is authorized. (b) The $7,500 service limit for Environmental Accessibility Adaptations and Specialized Medical Equipment and the **~~$39~~,000** service limit for Assistive Technology will be reviewed annually and utilization patterns analyzed. If it is necessary to adjust this amount the waiver will be amended. (c) If a person's need can't be met within a limit, an exception may be approved by the by the director or designee to exceed the limit if exceeding the limit will result in decreased need (units) of one or more other services. The service plan must document exceeding the limit for the service that will result in a decreased need of one or more other services. If it is determined the needs of a significant number of individuals cannot be met within the limitation, an amendment will be requested to increase the amount of the limitation. (d) Attempts will be made to locate another funding source or an exception may be requested and approved, see (c) above. **(e) & (f) When the individual has a need for these services, they are informed of the limitation. The limitation is listed within the description of the services which is available to participants, their legal representatives, advocates, and the public in general. The amount of the limit is published with the service definition.**
☐	**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-5: Home and Community-Based Settings

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Service Plan

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

b. Service Plan Development Safeguards.

Select one:

○	**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
X	**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	The state has safeguards in place to assure that the service providers' influence on the planning process (including exercising free choice of providers, controlling the content of the plan, including assessment of risk, services, frequency and duration, and informing the participant of their rights) is a part of the plan of care verification process before the plan is approved. The Division also has procedures for support coordinators to follow to ensure choice in providers, services, institutional care, and service delivery options are reviewed with the participant and legally authorized representative annually. The Division rules for targeted case management entities also require the

support coordinator to review choice, plan for services, risks, and one's goals without any undue influence from other providers or parties.

The Targeted Case Management (TCM) entity may provide waiver services, but NOT to an individual for whom the agency provides support coordination, unless that service is transportation. Any TCM entity that is also providing a waiver service to the same individual shall notify that individual during the annual plan development meeting, that the individual can no longer receive support coordination and waiver services from the same entity. The individual shall also be presented with the names of eligible TCM entities, along with alternative waiver service providers, to offer the individual a choice of either another TCM entity or waiver service provider.

The Division of Developmental Disabilities (Division) will be responsible for identifying future support coordination options for individuals who chose to continue to receive waiver services from a TCM entity. If the individual does not make a selection within 6 months, then the TCM entity shall make a referral to another TCM entity that agrees to accept the referral of individuals for TCM services. Full transition to a new provider of either waiver services or support coordination should be completed within one year of the annual plan development.

The existing case management provider shall notify DMH of the individual's choice and DMH shall effect the transfer. This system will be fully implemented by June 30, 2018.

~~**Entities that have responsibility for service coordination, including service plan development, sometimes also provide waiver services. Service coordinators do not also provide waiver services. When an entity provides both service coordination and waiver services, all quality management functions and actions are applicable as with any other waiver provider.**~~

~~**The Division of DD Quality Enhancement Staff ensures the entity acts in the best interest of the participant. To avoid potential conflicts of interest, the following steps are taken.**~~

~~**1.Division of DD Regional Offices are responsible for reviewing and approving all waiver eligibility determinations.**~~

~~**2.Entities providing both service coordination and waiver services must develop a conflict of interest plan specific to the service delivery area and its circumstances. This plan must include:**~~
~~**a. Information identifying potential conflict of interest situations;**~~
~~**b. Planned or ongoing agency initiatives intended to eliminate or mitigate the occurrence;**~~
~~**c. Agency actions intended to manage those ongoing situations that cannot be eliminated and may include but are not limited to: an open door policy, non-retribution and whistle-blowers' policies, rights committee review, and grievance policy. The grievance policy includes review and decisions of the agency; and**~~
~~**d. Methods of communication required to inform the individual consumer and/or guardian, if applicable, about the potential conflict.**~~

~~**3.During the annual service plan meeting the service coordinator will discuss potential conflict of interest and will inform the participant and family of all service options for**~~

	~~**meeting needs identified in the plan, and will offer choice of provider for each service to the participant and family. The option to choose an independent Community Specialist is also offered during the person centered planning process. Choices made by the participant and family are documented. The service plan must document that as a provider of service coordination and waiver services the agency will ensure its employees will act in the best interest of the participant and that no conflict of interest occurs. Individuals have the right to request an independent Community Specialist to develop the service plan.**~~ ~~**4.**~~***One of the Division's integrated quality functions is the targeted case management reviews conducted by the technical assistance coordinator (TCM TAC) reviews, which include*** ~~**The Division of DD's Quality Enhancement review of these entities includes:**~~ a. Verification that the conflict of interest statement is included in the ~~**service**~~ ***support*** plan; and b. Interaction/contact with a sample of consumers and/or their guardians to verify effectiveness of the procedures.

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

The ~~**interdisciplinary**~~ planning team responsible for the development of the individual ~~**service**~~ ***support*** plan ***should be led by the individual and*** must include the individual and his ***or her*** representative, family or guardian***, and any other individuals they choose***. When individuals are children under the age of 18 living with their family, the parent(s) choose who they want to attend as a member of the planning team, and the parent(s) must participate in the meeting.

~~**Division of DD Directive 4.060 requires all**~~ ***All*** ~~**service**~~ ***support*** coordinators ***must*** be trained on the Division of DD Person Centered Planning Guidelines prior to facilitating an individual ~~**service**~~ ***support*** plan. The guidelines describe person-centered planning as a process that is directed by the individual (waiver participant), with assistance as needed from a representative (~~**service**~~ ***support*** coordinator) and reinforces the responsibility of the ~~**service**~~ ***support*** coordinator to ensure that waiver participants are full partners in the planning process.

The guidelines are available to individuals and their families on the Division of DD's web page. ~~**The individual or legal representative must sign the completed plan.**~~ ***The support plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.***

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

including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The ~~**interdisciplinary**~~ planning team includes the individual and his or her representatives, family or guardian***, and other people chosen by the individual***. The individual chooses whom he/she wants to attend as a member of the team, unless the individual is a minor or has been judged incompetent, in which case the family or guardian must attend. The team also includes providers selected by the individual. Other professionals involved with the individual may be included as applicable and at the individual's invitation. ***The individual will lead the planning process where possible.*** The plan is usually facilitated by a ~~**service**~~ ***support*** coordinator employed by a Division of DD Regional Office or an approved Targeted Case Management Entity. If the person so chooses, another facilitator may be used, but the ~~**service**~~ ***support*** coordinator will participate in the planning. No later than 30 days from the date of acceptance into the waiver program the ~~**interdisciplinary**~~ planning team develops a ~~**service**~~ ***support*** plan with the individual. Initial plans must contain at least an accurate beginning profile of the person. The profile needs to reflect what the person sees as important in relationships, things to do, places to be, rituals and routines, a description of immediate needs, especially those that are important to the person's quality of life including health and safety and information about what supports and/or services are required to meet the person's needs. The plan facilitator must make sure that each item in the action plan has enough detail and/or examples so that someone new in the person's life understands what is meant and how to support the person. If the initial plan is not comprehensive, it can cover no more than 60 days, during which time a more comprehensive plan must be finalized.
The support plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. ~~**The service coordinator and the individual and/or his/her representative sign the completed plan prior to its implementation. All members of the planning team are provided a copy of the completed plan as appropriate.**~~ ***The plan must be distributed to the individual and other people involved in the plan.***
(b) The plan is based on the ~~**service**~~ ***support*** coordinator's functional assessment of the individual and all other assessments that are pertinent. Missouri uses the MOCABI (Missouri Critical Adaptive Behaviors Inventory) functional assessment tool for Adults and Vineland or other age appropriate tools for children. Assessments include observations and information gathered from the members of the team.
The functional assessment determines how the individual wants to live, the individual's routines, what works for the individual and what does not. It also assesses what the individual wants to learn and how the individual learns best. It measures how independently the individual functions and what interferes with what the individual wants, and it suggests ways the individual's needs and wants can be met.
c) Upon being determined eligible for Division of DD services, each individual and/or legal representative, or guardian receives information regarding available services and programs, including information about the waiver. After needs are identified through the planning process, the ~~**service**~~ ***support*** coordinator reviews this information once more and together with the individual and the interdisciplinary team specific services and supports are identified to meet the participant's needs.
d) ~~**Division of DD Division Directive 4.060 describes the process which service suppport coordinators must follow when developing a service**~~ ***Individual Support*** Plans must be written in accordance with Division of DD's Person Centered Planning Guide~~**lines**~~ and Missouri Quality Outcomes. The Person Centered Planning Guide~~**lines**~~ include***s*** a description of mandatory plan components. Mandatory components include: demographics; health and safety, who and what are important to the person; ***individual's strengths and preferences;*** what staff need to know and do to

provide support; requirements of the family of a minor child or guardian, how the person communicates and issues to be resolved. ***Setting options are identified and documented in the plan, based on the individual's needs, preferences, and, for residential settings, resources available for room and board. The plan reflects the setting in which the individual resides was chosen by the individual.*** ~~**The guidelines contain criteria for action plans including standards for developing outcomes and action steps.**~~

The plan specifies all the services and supports that are needed and who is to provide them, to enable the individual to live the way the individual wants to live and learn what the individual wants to learn. These methods may include teaching, which does not have to be behavioral. Learning can be incidental as long as it is planned. Providing supports or making adaptations to the environment may be part of the plan. The plan specifies any limitations the planning team foresees in being able to support the individual in achieving these desires. Such limitations can be financial, temporal and/or can relate to health and safety.

(e) ~~**Division of DD Service**~~ ***Individual Support*** Plans address all supports and services an individual is to receive. This includes services provided through the waiver, other state plan services and natural supports. For each need that is expressed, the plan must describe what support or service is being provided to meet that need. Providers selected by the ~~**consumer**~~ ***individual*** are responsible for providing services in accordance with the plan. The ~~**Division of DD service**~~ ***support*** coordinator is responsible for coordinating services provided by other agencies or individuals and monitoring the provision of services during routine monitoring visits.

(f) Each outcome on the plan must be accompanied by information regarding the person(s) responsible for assuring progress. Timelines for completion of each Outcome is specified. ~~**Service**~~ ***Support*** Coordinators monitor this progress during plan review visits.

(g) ~~**Service**~~ ***Individual Support*** plans are subject to continuous revision. At a minimum, the entire team performs a formal review at least annually. The ~~**service**~~ ***support*** coordinator maintains at least quarterly contact with each individual, their family or guardian ***with at least an annual face to face contact for the individual who resides in their natural home setting. Monthly f***ace to face contact is required for ~~**persons**~~ ***individuals*** in residential placement ~~**and at least annually for those persons who live with their family**~~. During quarterly contact, the ~~**service**~~ ***support*** coordinator monitors the individual's health and welfare. Progress notes document the contact and whether the outcomes stated in the plan are occurring. ~~**and whether the outcomes set forth in the Missouri Quality Outcomes are a reality for the person.**~~

~~**service S**~~***upport*** coordinators are responsible for reviewing the provider's notes at least quarterly, and for observing and documenting any problems, discrepancies, dramatic changes or other occurrences which indicate a need for renewed assessment. The ~~**service**~~ ***support*** coordinator's review of the provider notes includes making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk. During monitoring and record reviews, the ~~**service**~~ ***support*** coordinator determines if the ***support*** plan ~~**of care**~~ continues to meet the needs of the individual and with the approval of and input from the individual, their family or guardian, and makes any necessary revisions.

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

The Person Centered Planning Guide~~lines~~ require***s*** that ***support*** plans ~~of care~~ identify risks to individuals to assure their health and welfare. When the ~~person~~ ***individual*** will be learning or doing something that involves increased risk, the plan or action plan will describe: 1) Action taken to assure the ~~person~~ ***individual*** is making an informed choice, including a description of what has been done to assure that the person clearly understands what risks are involved and possible consequences; 2) What the ~~person~~ ***individual*** needs to know and the skills and supports that are necessary for the ~~person~~ ***individual*** to achieve his/her goal; 3) How supports will be provided, skills that will be taught and by whom; 4) What others in the community need to know and do to provide support to the individual; and 5) What follow-up and monitoring will occur.

A Health Inventory assessment is completed ***on an annual basis*** ~~on~~***for*** all individuals in waiver residential placement. ~~**The inventory is completed on an annual basis in accordance with preparation for the annual plan review process.**~~ The inventory must also be completed on individuals who experience a significant change in physical or mental health status. ~~**Once t**~~The ~~service~~ ***support*** coordinator completes ***the electronic health inventory. Once completed, the designated Regional Quality Enhancement (QE) RN is notified and determines based upon the health inventory score whether a QE nurse review is required.*** ~~**the tool it is submitted to the Regional Center RN III for scoring. Those individuals meeting scoring criteria, as determined by the RN, receive a Nursing Review by the RN. Following the Nursing Review, the nurse makes any necessary revisions to the inventory and provides the service coordinator with a copy of the revised inventory. The Health Inventory is maintained in the consumer's record.**~~ ***When a QE nurse review is conducted, findings are electronically communicated to the support coordinator for remediation.*** All Health indicators identified on the Health Inventory are considered significant and are ***to be*** discussed along with necessary supports in the appropriate section of the ~~**person centered**~~ ***support*** plan. The ~~**Service**~~ ***Support*** Coordinator is responsible for inclusion of health information in the ~~**personal**~~ ***support*** plan and consults with the ***QE*** RN with any questions.

Providers and lead agencies are responsible for back-up plans and this is part of the service that they provide. There are back-up plans for everyone and the agency should inform individuals about what the back-up plan is and what is contained in the back-up plan.

Individuals who self direct services are required to include a back up plan in their ***support*** plan~~**of care**~~. Back up plans include a description of the risks faced when emergencies, such as lack of staff arises. The back up plan also identifies what must be done to prevent risks to health and safety; how people should respond when an emergency occurs; and who should be contacted and when. Back up plans must list at least 2 individuals who will provide support when regular staff is not available.

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

When more than one provider of service is enrolled as a waiver provider, the ~~**participant**~~ ***individual*** or legal guardian is given a choice among eligible providers. The ~~**service**~~ ***support*** coordinator ***educates and informs*** ~~**provides information**~~ ***individuals*** regarding eligible providers ***of services*** to the individual or guardian during the ***annual*** planning process***, and at any other time as needed***. The ~~**Client Choice of Provider Statement**~~ ***Medicaid Waiver, Provider, and Services Choice Statement*** is used ***in conjunction with educating and informing individuals of eligible providers*** for ~~**this purpose**~~ ***documentation of provider choice***. ***Documentation of education and***

choice of providers must be included in the annual plan. Attached to the choice statement is the list of eligible providers for the given service. The Regional Office or Targeted Case Management Entity that is providing ~~service~~ ***support*** coordination is responsible for ensuring ~~consumer~~ ***individual*** choice of provider statements are obtained and maintained in the individual's case record.

The Division of DD makes every effort to build provider capacity in rural areas. Each regional office has Provider Relations staff designated to work with provider development. If there are limited providers available for a chosen service the Division will work closely with the individual to identify other providers that would be willing to provide the needed service in the area of the state where the ~~consumer~~***individual*** resides.

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):

Annually, MO HealthNet selects a statistically valid sample (95% confidence level and a plus or minus 5% margin of error rate)of waiver ~~service~~ ***support*** plans for review. This review by staff from the State Medicaid Agency ensures individuals receiving waivered services had a ~~service~~ ***support*** 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** ~~service~~ ***support*** plan were properly authorized prior to service delivery.

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

○	**Every three months or more frequently when necessary**
○	**Every six months or more frequently when necessary**
X	**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**
X	**Operating agency**
☐	**Case manager**
X	**Other** *Specify:*
	Approved Targeted Case Management Entities that provide ~~service~~ ***support*** coordination, including ~~service~~ ***support*** plan development, maintain the ~~service~~ ***support*** plans of ~~participants~~ ***individuals*** for whom they coordinate services.

Appendix D-2: Service Plan Implementation and Monitoring

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

a.) Monitoring the implementation of the ~~**service**~~ ***support*** plan and the participant health and welfare is the responsibility of the ~~**interdisciplinary team**~~ ***planning team*** (Code of State Regulation 9 CSR 45-3.010). This process is facilitated by the ~~**service**~~ ***support*** coordinator employed by a Division of DD Regional Office or an approved Targeted Case Management Entity, and designated management staff from the community provider.

b.) & c.) ~~**service**~~ ***support*** plans and participant health and welfare are monitored and follow–up action is taken through the following processes and frequencies:

1) ~~**service**~~ ***Support*** coordinators monitor health, fiscal issues, services and staff, environment and safety, and consumer rights during monitoring visits with the participant, per the Service Monitoring Policy and Implementation Guidelines ~~**(Division Directive 3.020).**~~ At a minimum of quarterly, the ~~**service**~~ ***support*** coordinator monitors the health and welfare of the participant. These quarterly reviews include a review of the service plan to ensure service needs identified in the plan are being met. The review is accomplished by reading provider progress notes, contact with the individual and/or responsible party, and through observation. If non-waiver service needs are identified in the service plan, the ~~**service**~~ ***support*** coordinator determines the person or entity identified in the service plan as responsible for helping the individual access the service(s) and determines if services are being received as planned. Non-waiver services may include health services the individual accesses through State plan Medicaid services. Review of the ~~**service**~~ ***support*** plan and the person's health and safety includes a review of the backup plan for participants who self direct. Monitoring considers whether the backup plan has been implemented, and if so, whether the plan sufficiently met the individual's needs and whether all persons and entities named as part of the backup plan are still available to assist. If changes are needed to the backup plan, the service plan will be updated accordingly. Results are documented in a quarterly review note or a case note when the monitoring was not part of the quarterly review process.

When an issue or concern is discovered around an individual's health, safety/environment, rights, money, services, or back-up plan, the ~~**service**~~ ***support*** Coordinator supervisor, consumer's guardian and/or the provider's designated management staff are notified. If a concern is not an immediate risk to the person's health or welfare and cannot be quickly resolved then the ~~**service**~~ ***support*** coordinator indicates the type of action plan that will be taken to address the issue. Concerns around the sufficiency of the backup plan shall be immediately resolved which will include a revised service plan. All issues/concerns ***identified from support monitoring and ISP Review processes*** and action taken are entered in the Division's A***ction***~~**gency**~~ Plan~~**ning**~~ Tracking System (APTS) for trending and tracking purposes. ~~**service**~~ ***support*** coordinators are employed by the state or by Targeted Case Management entities. Both are responsible for reporting information in***to*** ~~**the State's Agency Planning Tracking System**~~ (APTS) and for maintaining case notes.

If monitoring discovers there is a lack of progress on achieving the outcomes identified in the ~~**service**~~ ***support*** plan, the ~~**service**~~ ***support*** Coordinator documents this and works with the individual and the interdisciplinary team to revise and amend the plan as needed. ~~**service**~~ ***support*** plan revisions can only be implemented with the approval of the individual or their guardian.

Visits with consumers participating in on-site day habilitation programs are quarterly. Consumers

participating in off-site day habilitation receive quarterly face-to-face visits with at least one annual visit at the off-site location where the service is received.

2) The ~~service~~ ***support*** Plan Review process ensures the individual planning process is person-centered and leads to quality outcomes for individuals. The process also evaluates the effectiveness of support services in meeting individual needs, identifies support service strengths, and areas needing improvement. Each person supported by the Division must have a service plan that meets the minimum criteria described in the Division of Developmental Disabilities ~~**Directive 4.060**~~ Individual Service Plan: Guidelines, Training and Review.
~~**service**~~ ***support*** plans must be reviewed and updated if necessary on at least a quarterly basis. The review and update must also occur when:
a) the person or the person's guardian requests that information be changed or added;.
b) others invited by the person to participate in his/her ~~**service**~~ ***support*** plan provide additional information;
c) needs for supports and services are not being adequately addressed;
d) a back-up plan failed or needs to be revised due to a change in the availability of persons named or entities named; or
e) the need for support and service changes.

3) The MO HealthNet Division reviews a statistically valid random sample ***(statistically valid sample 95% confidence level and a plus or minus 5% margin of error rate)*** of waiver participant records annually. The compliance review includes looking at individual service plans. Information reviewed may include the plan of care, level of care evaluation, annual re-determination of the level of care, assessments used to determine the level of care, service reviews completed by ~~**service**~~ ***support*** coordinators, provider monthly reviews of the service plan, provider choice statements completed by the consumer, and waiver choice statements completed by the consumer. The review by MO HealthNet ensures all service needs identified in the service plan are being met regardless of the funding source for support. If there is not evidence that a need in a person's service plan is being met, this is a review finding which will be referred back to the regional office or county entity. Depending on the urgency of ensuring the need is met, a phone call may be placed or the request for corrective action will be provided in writing. Federal Programs Division of DD staff is responsible for ensuring that corrective action is taken and for reporting the action to MO HealthNet.

4) ***A random review (statistically valid sample of 95% confidence level and a plus or minius 5% margin of error rate) of Individual Support Plans is completed on a quarterly basis. This includes both*** ~~**Each**~~ regional office***, as well as contracted TCM agencies which*** ~~**and County Board that**~~ provide~~**s**~~ case management***. The review is conducted by Division of DD staff on a statistically valid sample of waiver participants to ensure adherence to CMS waiver and Division of DD requirements.***
~~**is responsible for random reviews of service plans on a quarterly basis to ensure all required components of each service plan is in place.**~~

~~**5)Designated Targeted Case Management (TCM) who have received training in and have knowledge of the individual service plan required components monitor selected plans, including subsequent amendments, and all documentation of monthly progress for the past 12 months. The review is designed to be conducted on a statistically valid sample of waiver participants and to ensure adherence to CMS waiver and Division of DD requirements.**~~

5)Health Identification Planning System (HIPS), outlines medical considerations to be screened annually for each consumer who receives a residential service. When there is a significant change in health status, and when a consumer moves into residential care for the first time, the ~~**case manager**~~ ***support coordinator*** completes a Health Inventory screening tool. When a threshold of health or

medical needs is reached, guidelines and criteria are provided for the completion of a more thorough review by a regional office nurse. This process ensures that health care needs are identified and included in the service plan for each consumer, and provides guidance for direct support staff to facilitate good health practices for consumers. Although HIPS is primarily targeted to individuals in placement, the process can also be initiated for persons living at home, including individuals who are self directing services.

6) Issues and remediation identified through monitoring, are entered into the Division of DD's Action Plan Tracking Systems (APTS). Reports are shared with the Medicaid Agency annually, upon request, or when critical events related to health and safety occur.

(d) ~~**Service Support coordination**~~***TCM TAC ISP Review*** monitoring includes ensuring the individual has free choice of provider for all waiver services. Initially a form is completed to reflect choice of provider. If a new service is initiated, or a new provider is identified, the SC would complete a new form to verify provider choice. Quarterly a random sample of individual service plans and associated documentation are reviewed through the Individual Service Plan review ~~**survey**~~.

b. Monitoring Safeguards. *Select one:*

○	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
X	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.** The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	Some entities that provide ~~**service**~~ ***support*** coordination and therefore have responsibility for monitoring service plan implementation and participant health and welfare, may also provide direct waiver services. ~~**Service**~~ ***Support*** coordinators do not provide other direct services. ***The state has safeguards in place to assure that the service providers' influence on the planning process (including exercising free choice of providers, controlling the content of the plan, including assessment of risk, services, frequency and duration, and informing the participant of their rights) is a part of the plan of care verification process before the plan is approved. The Division also has procedures for support coordinators to follow to ensure choice in providers, services, institutional care, and service delivery options are reviewed with the participant and legally authorized representative annually. The Division rules for targeted case management entities also require the support coordinator to review choice, plan for services, risks, and one's goals without any undue influence from other providers or parties.*** ***The Targeted Case Management (TCM) entity may provide waiver services, but NOT to an individual for whom the agency provides support coordination, unless that service is transportation. Any TCM entity that is also providing a waiver service to the same individual shall notify that individual during the annual plan development meeting, that the individual can no longer receive support coordination and waiver services from the same entity. The individual shall also be presented with the names of eligible TCM entities, along with alternative waiver service providers, to offer the individual a choice of***

either another TCM entity or waiver service provider.

The Division of Developmental Disabilities (Division) will be responsible for identifying future support coordination options for individuals who chose to continue to receive waiver services from a TCM entity. If the individual does not make a selection within 6 months, then the TCM entity shall make a referral to another TCM entity that agrees to accept the referral of individuals for TCM services. Full transition to a new provider of either waiver services or support coordination should be completed within one year of the annual plan development.

The existing case management provider shall notify DMH of the individual's choice and DMH shall effect the transfer. This system will be fully implemented by June 30, 2018.

The Division of DD has the following safeguards to ensure monitoring is conducted in the best interests of the participant:

1)~~**Participants**~~ Individuals have the option to choose a different entity to monitor the plan when more than one case management entity is available in the area. Participants also have the option to request a different ~~**service**~~ ***support*** coordinator from the same case management entity be assigned.

2)~~**Division Operating Directive, 3.020,**~~ Service Monitoring Policy and Implementation Guidelines, sets monitoring standards that all service coordinators must follow in reviewing environment/safety, health, services and staff, money and rights.

3) ~~**service**~~ ***Support*** coordinator entities are included in ~~**service**~~ ***support*** coordination and waiver related training conducted by Regional Offices.

4)All ~~**service**~~ ***support*** coordinator entities are responsible for reviewing a sample of service coordination log activities each month for their staff and for reporting the results to the Division's Statewide Quality Enhancement Leadership Team. Some of the log notes in the sample would include results of monitoring activities and any corrective action taken.

5)Monitoring activities are subject to the review of the Division of DD, the operating agency, and the State Medicaid Agency, MO HealthNet. Annually MO HealthNet randomly selects waiver participants for a compliance review. The review includes reviewing plans of care and quarterly reviews from monitoring. Participants served by entities that provide both waiver services and monitor the services are subject to this review.

6)Division of DD Regional Office Quality Enhancement staff review the performance of entities that provide ~~**service**~~ ***support*** coordination. The review includes interaction/contact with a sample of individuals and/or their guardians to verify the effectiveness of ~~**service**~~ ***support*** coordination they have received. Corrective action is taken if there is evidence a participant has health and welfare issues that have not been met or is dissatisfied with ~~**service**~~ ***support*** coordination.

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**

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.

i. Performance Measures

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

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

Performance Measure:	*Number and percent of* ~~**plans of care**~~ ***support plans*** *in which services and supports are aligned with assessed needs (Number of* ~~**plans of care**~~ ***support plans*** *in**dicating*** ~~**which**~~ *supports and services are aligned with assessed needs* ***reviewed within the identified quarter divided by*** *Total number of* ~~**plans of care**~~ ***support plans reviewed in the identified quarter*** ~~**waiver participants in the sample**~~*)*		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify:			
Record Reviews, ~~**on**~~***off****-site*			
	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)*
	~~**X**~~ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*XLess than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	*X Representative Sample; Confidence Interval =.95*

State:	
Effective Date	

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

Add another Data Source for this performance measure

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*
~~X~~ *State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	*Number and percent of* ~~**waiver participants who have**~~ ***support plans*** ~~**plans of care that**~~ *address* ***ing identified*** *health* **risks** ~~*as indicated in the assessmen*~~*t. (Number of* ***support plans*** ~~**plans of care**~~ *addressing* ***identified*** *health risks* ***as reviewed within the identified quarter divided by*** *Total number of* ***support plans*** ~~**plans of care**~~ ***reviewed in the identified quarter.*** ~~**waiver participants with identified health risk in the sample**~~*)*
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

Record Reviews, off-site ~~**on-site**~~			
	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)*
	~~X~~ ☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	*X Representative Sample; Confidence Interval =.95*

State:	
Effective Date	

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

Add another Data Source for this performance measure

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*
~~X~~ ☐ *State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	*Number and percent of* ~~**waiver participants who have**~~ ***support plans*** ~~**plans of care**~~ *address**ing participant's*** ~~***their***~~ *desired outcomes* ~~**as indicated in the assessment**~~. *(Number of* ~~**waiver participants with**~~ ***support plans*** ~~**plans of care**~~ ***addressing participants' desired outcomes*** ~~**adequate and appropriate to desired outcomes**~~ ***divided by*** *Total number of* ***support plans*** ~~**plans of care**~~ ***reviewed in the identified quarter*** ~~**waiver participants in the sample**~~*)*
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Record Reviews, ***off****-site* ~~**on-site**~~	

	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)*
	~~X~~ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	*X Representative*

State:	
Effective Date	

				Sample; Confidence Interval =.95
	☐ *Other Specify:*	☐ *Annually*		
		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

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*
~~**X**~~ *State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	*Number and percent of* ~~**waiver participants who have**~~ ***support plans***~~**of care that**~~ *address**ing*** ~~**participants**~~ ***individuals' identified*** *safety risks*~~**as indicated in the assessment**~~. *(Number of* ~~***waiver participants with***~~ ***support plans*** ~~**plans of care**~~ *addressing* ~~**participants**~~ ***individuals' identified*** *safety risks* ***divided by*** *Total number of* ***support plans*** ~~**plans of care**~~ ***reviewed in the identified quarter*** ~~**waiver participants in the sample**~~*)*
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Record Reviews, ***off****-site* ~~**on-site**~~	

	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)*
	~~**X**~~ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	*X Representative Sample; Confidence*

State:	
Effective Date	

				Interval =.95
	☐ *Other Specify:*	☐ *Annually*		
		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

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*
~~X~~ *State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

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

i. Performance Measures

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

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

Performance Measure:	*Number and percent of* ***support plans*** ~~**plans of care**~~ *reviewed in accordance with the state's policy for monitoring (number of* ***support***

	plans ***~~plans of care~~*** *reviewed* ***divided by*** ***/ ~~over the~~*** *number of* ***support plans*** ***~~plans of care~~*** ***required to be reviewed in the*** *identified* ***~~timeframe~~*** ***quarter*** ***~~in the sample for monitoring~~***)

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

~~Record reviews on-site~~ ***Analyzed Collected Data***

	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*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	~~X~~ *☐ Sub-State Entity*	*☐ Quarterly*	*X Representative Sample; Confidence Interval = .95*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	*Number and percent of* ***support plans*** ***~~plans of care~~*** *reviewed for people who are self-directing that contain a back-up plan (number of* ***support plans*** ***~~plans of care~~*** ***for individuals self-directing containing a back-up plan divided by*** ***/ ~~reviewed containing the back-up plan over the total~~***

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	number of ***support plans*** ***~~plans of care~~*** ***for individuals self-directing*** *reviewed* ***within the identified*** ***~~timeframe~~quarter~~in the sample~~*** *)*

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

Record reviews ***off-site*** ***~~on-site~~***

	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*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	~~X~~ ☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval = .95*
	☐ *Other Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

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*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	*Number and percent of plans in which the person/person's guardian signed and dated the plan prior to implementation (Number of* ***support plans*** ***~~plans of care~~*** *where the* ***~~person~~*** ***individual/~~person's~~individual's*** *guardian signed and dated prior to implementation date* ***divided by ~~/ over the total~~*** *number of plans reviewed in the* ***identified*** ***~~timeframe~~ quarter***

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	~~***sample***~~*)*
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	
Record reviews ***off-site*** ~~**on-site**~~	

	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*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	~~***X***~~ ☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval = .95*
	☐ *Other Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

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*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	*Number and percent of plans that describe what people need to know or do in order to support the* ~~**person-**~~***individual*** *(Number of plans* ***within the sample*** ~~**reviewed that**~~ *describ****ing*** *what people need to know or do in order to support the* ~~**person-**~~***individual divided by*** ~~**/ over the total**~~ *number of plans reviewed* ***within the identified*** ~~**timeframe**~~ ***quarter*** ~~***in the sample***~~*)*
Data Source *(Select one) (Several options are listed in the on-line application):*	

State:	
Effective Date	

If 'Other' is selected, specify:			
Record reviews ***off-site*** ~~**on-site**~~			
	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*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	~~X~~ ☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = .95*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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

i. Performance Measures

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

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

Performance Measure:	*Number and percent of* ***support plans*** ~~**plans of care**~~ *updated/ revised at least annually. (Number of* ~~**Waiver Participants whose**~~ ***support plans*** ~~**plans of care were**~~ *updated/revised* ***at least*** *annually* ~~**[indicated by Service coordinator signature on the person centered plan prior to the implementation date]**~~ ***divided by*** ~~**Total**~~ *number of* ***support plans*** ~~**plans of care**~~ ***reviewed within the identified timeframe*** ~~**quarter waiver participants in the sample**~~*)*

Data Source *(Select one) (Several options are listed in the on-line application): Record reviews* ***off-site*** ~~**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*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	~~X~~ ☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval = .95*
	☐ *Other Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

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:	
Effective Date	

~~X~~ ☐ *State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	*Number and percent of* ***support plans*** ~~**plans of care**~~ ***that were updated to reflect identified changes in need*** ~~**participants who had a change in need and the Plan of care was updated**~~. *(****Number of support plans*** ~~**plans of care**~~ ***reflecting identified changes in need*** ~~***Total number of waiver participants whose plans were changed to reflect their needs***~~ ***divided by*** ~~**Participants who had a change in need**~~ ***Number of support plans*** ~~**plans of care**~~ ***reviewed within the identified timeframe*** ~~***quarter***~~*)*
Data Source *(Select one) (Several options are listed in the on-line application): Record reviews off-site* ~~**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*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	~~X~~ ☐ *Sub-State Entity*	☐ *Quarterly*	*X Representative Sample; Confidence Interval = .95*
	☐ *Other Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis	***Frequency of data aggregation and analysis:***

State:	
Effective Date	

(check each that applies	*(check each that applies*
~~X~~ ☐ State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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

i. Performance Measures

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

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

Performance Measure:	*Number and percent of* ***~~waiver participants~~ individuals*** *who receive services in the type, amount, frequency, and duration* ***~~specified~~authorized*** *in their* ***support plans ~~plans of care~~****. (Number of* ***~~waiver participants~~ individuals who receive services as authorized in their support plans ~~plans of care~~ ~~with no issues identified that were related to services being provided as authorized in their plan~~ divided by ~~Total~~*** *number* ***of ~~waiver participants~~ individuals with authorized services within the identified timeframe ~~quarter~~****)*		
Data Source *(Select one) (Several options are listed in the on-line application):* ***On-Site Observation, Interviews, and Monitoring***			
If 'Other' is selected, specify:			
On-site observations, interviews, and monitoring			
	Responsible Party for data collection/generation	***Frequency of data collection/generation:*** *(check each that*	***Sampling Approach*** *(check each that applies)*

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

Add another Data Source for this performance measure

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*
~~X~~ ☐ *State Medicaid Agency*	☐ *Weekly*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	***X Quarterly***
☐ *Other Specify:*	✓ ***Annually***
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

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

i. Performance Measures

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

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

Performance Measure:	*Number and percent of* ***~~waiver participants whose records contained an appropriately~~*** *completed and signed Medicaid Waiver****, Provider, and Services*** *Choice Statements* ***~~form that~~*** *specif****ying*** ***~~ies that~~*** *choice was offered between waiver services and institutional care. (Number of* ***~~waiver participants with a~~*** ***completed and*** *signed* ***Medicaid Waiver, Provider, and Services Choice Statements confirming choice of waiver participation*** ***~~Medicaid Waiver Choice Statement ÷~~*** ***divided by*** ***~~Total~~*** *number of* ***records reviewed within the identified timeframe*** ***~~quarter~~*** ***~~waiver participants in the sample population~~*** *)*
Data Source *(Select one) (Several options are listed in the on-line application): Record Reviews-off-site* ***~~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*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	~~X~~ ☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = .95*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
~~X~~ ☐ State Medicaid Agency	*☐ Weekly*

State:	
Effective Date	

X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	*Number and percent of* ***~~waiver participants whose records contained a~~*** *completed and signed* ***Medicaid Waiver, Provider, and Services Choice Statements indicating choice was offered between providers***. ***~~Medicaid Waiver Client Choice of Provider Statement~~***. *(Number of* ***~~waiver participants with a~~*** ***completed and*** *signed* ***Medicaid Waiver, Provider, and Services Choice Statements indicating choice was offered between providers divided by*** ***~~total~~*** *number of* ***records reviewed within the identified timeframe*** ***~~quarter~~*** ***~~waiver participants in the sample~~***)

Data Source *(Select one) (Several options are listed in the on-line application): Record Reviews-* ***off-site*** ***~~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*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	~~X~~ ☐ Sub-State Entity	*☐ Quarterly*	*X Representative Sample; Confidence Interval = .95*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

State:	
Effective Date	

applies	*applies*
~~X~~ ☐ State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	***Number and percent of completed and signed Medicaid Waiver, Provider, and Services Choice Statements indicating*** *choice was offered between waiver services.* ***~~Number and percent of waiver participants who were offered choices of waiver services was offered~~*** *(Number of* ***completed and signed Medicaid Waiver, Provider, and Services Choice Statements indicating choice was offered between waiver services ~~waiver participants offered choice of services ÷~~ divided by ~~total~~*** *number of* ***records reviewed within the identified timeframe ~~quarter~~ ~~waiver participants in the sample~~****.)*

Data Source *(Select one) (Several options are listed in the on-line application): Record Reviews-* ***off-site ~~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*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	~~X~~ ☐ Sub-State Entity	*~~X~~ ☐ Quarterly*	*X Representative Sample; Confidence Interval = .95*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

State:	
Effective Date	

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

Add another Performance measure (button to prompt another performance measure)

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. In addition, provide information on the methods used by the State to document these items.*

(a.1.a, a.1.b., a.1.c., & a.1.e) ~~**Service**~~ ***Support*** Plan ~~**(SP)**~~ reviews are conducted by ~~**Service**~~ ***Support*** Coordinator Supervisors and remediation tracked through a web based survey application. At the time of ~~**service**~~ ***support*** plan review, the choice statements are verified. If a plan does not meet criteria set forth in the ~~**SP**~~***support plan*** components or the choice statements are not completed, the ~~**Service**~~ ***Support*** Coordinator Supervisor/designee reviews the finding with the appropriate ~~**service**~~ ***support*** coordinator and the error is corrected and noted on the ***support plan*** ~~**SP**~~ review. General methods for problem correction include revising the plan, providing remedial training for the ~~**Service**~~ ***Support*** Coordinator, point of discussion during unit meetings and/or change in Division policy or procedure. The ~~**Service**~~ ***Support*** Coordinator Supervisors/designee and regional office/agency director is responsible for determining if personnel actions are needed for individual ~~**case managers**~~ ***support coordinators***, including, but not limited to, training or re-training, verbal or written warnings,

suspension or termination.

For errors related to service provision, resolution may occur in two different ways. 1) ***Support*** ~~**Service**~~ coordinator can resolve on site if applicable, or 2) designated Quality Enhancement Staff may be notified for additional follow-up and resolutions. This issue is entered in to the Action Plan Tracking System Database, ***and*** the follow-up is documented in provider file or consumer case notes. ~~**Remediation reported as: completed within 30 days, 31 to 60 days, more than 61 days and not completed.**~~

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):*
	X State Medicaid Agency	☐ **Weekly**
	X Operating Agency	☐ **Monthly**
	☐ **Sub-State Entity**	**X Quarterly**
	☐ **Other** Specify:	**X 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**
X	**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):*

X	**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
○	**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

○	**Yes. The State requests that this waiver be considered for Independence Plus designation.**
X	**No. Independence Plus designation is not requested.**

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a) Expectations for Person Centered Planning, ~~**Division Directive 4.060,**~~ reflect the values outlined in the Missouri Quality Outcomes. Those outcomes acknowledge principles that people have control of their daily lives, and that plans should reflect how they want to live their life. Person-centered planning is the foundation in which people can determine the direction of their lives, identify the supports they will need, and how those supports should be delivered to assist them to move in their personally identified direction. The planning process is under the direction of the individual or a representative of their choice. The process identifies needs and how those will be met by both paid and unpaid supports, who will provide the supports, and how supports will be provided within agreed upon parameters.

b) Individuals/guardians or designated representatives may choose to self-direct personal assistant services ***and*** community specialist ~~**and support broker**~~ services and be the employer though a VFA FMS Services. All Individuals have a ~~**service**~~ ***support*** coordinator trained to facilitate the person centered planning process, but they may also use Community ~~**Professional**~~***Specialist*** or Support Broker for information and assistance in defining goals, needs and preference, identifying and accessing services, supports and resources as part of the person centered planning process which is then gathered by the ~~**service**~~ ***support*** coordinator for the ~~**Service**~~ ***Support*** Plan. Individual/guardians or designated representatives direct how their negotiated individualized budget is to be expended to exercise control of their allocated resources. They have the option to h***ave*** ~~**ire**~~ a support broker to provide information and assistance in order to help in recruiting, hiring, and supervising staff. The individual/guardian or designated representative is the common law employer with the assistance of a Vender/Fiscal Agent FMS who will perform payroll, taxes, broker workers compensation, etc.

c) Resources available to support individuals who direct their services include the ability of the participant/guardian or designated representative to facilitate the ~~**service plan**~~ ***support plan with the assistance of the support coordinator.*** ~~**or hire an independent person centered plan facilitator.**~~ The individual/guardian or designated representative recruits, hires and self-directs employees and performs other employer supervisory duties. Individuals/guardians or designated representatives may ***be authorized for*** ~~**hire**~~ a support broker ~~**or choose a support broker that works for an agency**~~ to provide ~~**the**~~ assistance. Financial management services are available for individuals who self direct. The financial management contractor provides the individual or representative with technical assistance in getting employees set-up for payroll services and in tracking expenditures. S***upport*** ~~**ervice**~~ coordinators are responsible for monitoring: health and safety, ensuring individuals stay within budgeted allocations, and required documentation is created and maintained. Additionally the s***upport*** ~~**ervice**~~ coordinator is responsible in informing individuals of the option to Self-Direct. A support broker is an option for individuals who need additional information and assistance in managing and directing their employees. The self-directed supports coordinator is a state employee who is available to provide technical assistance, creat***e system*** ~~**ing**~~ enhancements, track~~**inging**~~ and trend ***issues***~~**ing**~~, and ***provide*** oversight of the option to self direct.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
X	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

X	**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
☐	**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
☐	**The participant direction opportunities are available to persons in the following other living arrangements** *Specify* these living arrangements:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	**Waiver is designed to support only individuals who want to direct their services.**
○	**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
X	**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.** *Specify the criteria*
	Only Personal Assistant, ~~**Support Broker,**~~ and Community Specialist may be self-directed. For individuals who do not choose to self-direct, waiver services are available through MO HealthNet enrolled waiver provider agencies. Only individuals who live in their own private residence or the home of a family member may self direct.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) Individual/guardians or designated representatives learn about self directed support options from the ~~**service**~~ ***support*** coordinator during the person centered planning process when needs are identified and ways of supporting the needs are discussed. Self directed supports is listed on ***the Medicaid Waiver, Provider, and Services Choice Statement***~~**Free Choice of Provider form.**~~
Individual/guardians or designated representatives also often learn about self directed supports from other individuals or families who are directing their own services. Information on self directed services is included in the waiver manual which is available to the public. The waiver manual and the Individual handbook on self directed support is also available on the DMH/Division of DD web-site. The information assists ~~**service**~~ ***support*** coordinators in describing the benefits and processes for self-direction and provides written material for individuals and/or legal representatives on the specifics. Regional offices have a Self-Directed Coordinator that is available to provide technical assistance and guidance to ~~**service**~~ ***support*** coordinator and other stakeholders. As part of the person centered planning process, the specialized needs of the individual are discussed with the planning team to identify any potential liabilities or risks the individual may face, and to determine a plan for how each potential liability and risk will be addressed.

b) Developmental Disability Targeted Case Management Entities providing ~~service~~ ***support*** coordination are responsible for furnishing information on self direct supports options.

c) Developmental Disability Targeted Case Management Entity ~~service~~ ***support*** coordinators are trained on self directed supports options. If the ~~service~~ ***support*** coordinator hasn't been through the training, regional office self-directed coordinators may be asked to assist in providing information to the individual with the~~service~~ ***support*** coordinator. This information is presented during the person centered planning process when individual needs are identified and ways of supporting the needs are discussed, anytime the individual is dissatisfied with provider based services, or upon inquiry by the participant/guardian or designated representative.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

	The State does not provide for the direction of waiver services by a representative.	
X	**The State provides for the direction of waiver services by representatives.** Specify the representatives who may direct waiver services: *(check each that applies)*:	
	X	**Waiver services may be directed by a legal representative of the participant.**
	X	**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		An Individual's Right to Have a Designated Representative An individual who is 18 years or older has the right to identify a designated representative. ~~**The designated representative becomes the common law employer.**~~ The designated representative is responsible for managing employee(s), acting in the best interest of the individual, in accordance with the guiding principles of self-determination. If a representative has been designated by a court, the legal guardian will identify themselves or another person as the representative. A designated representative must: 1. Direct and control the employees' day to day activities and outcomes. 2. Ensure, as much as possible, that decisions made would be those of the individual in the absence of their disability; 3. Accommodate the individual, to the extent necessary, so that they can participate as fully as possible in all decisions that affect them; accommodations must include, but not be limited to, communication devices, interpreters, and physical assistance; 4. Give due consideration to all information including the recommendations of other interested and involved parties; and 5. Embody the guiding principles of Self-Determination 6. Not be paid to provide any supports to the individual. The following people can be designated as a representative, as available and willing: • A spouse (unless a formal legal action for divorce is pending) • An adult child of an individual • A parent • An adult brother or sister

• Another adult relative of the individual
• Other representative — If the individual wants a representative but is unable to identify one of the above, the individual along with their ***Support*~~service~~** coordinator, and planning team, may identify an appropriate representative. The 'other representative' must be an adult who can demonstrate a history of knowledge of the individual's preferences, values, needs, etc. The individual and his or her planning team is responsible to ensure that the selected representative is able to perform all the employer-related responsibilities and complies with requirements associated with representing one individual in directing services and supports.

The planning team and Fiscal Management Service Provider (FMSP) must recognize the individual's representative as a decision-maker and provide the representative with all of the information, training, and support these entities would typically provide to a individual who is self-directing. The representative must be informed of the rights and responsibilities of being a representative. Once fully informed the representative must sign an agreement which must be given to the representative and maintained in the individual's record. The agreement must list the roles and responsibilities of the representative, the roles and responsibilities of the FMSP, must include that the representative accepts the roles and responsibilities of this function; and state that the representative will abide by the FMSP policies and procedures. The designated representative must function in the best interest of the individual and may not also be paid to provide services to the individual. The Individual can at any time revoke the agreement with the designated representative.

Service Monitoring takes place with each waiver participant as outlined in Appendix D-2. The monitoring process can lead to identifying issues with the representative not acting in the best interest of the waiver participant.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
~~**Support Broker**~~	~~**X**~~	~~**X**~~
Personal Assistant	X	X
Community Specialist	X	X
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

X	**Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).* Specify whether governmental and/or private entities furnish these services. *Check each that*

	applies:	
	☐	**Governmental entities**
	X	**Private entities**
○	**No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service specified in Appendix C-1/C-3 **The waiver service entitled:**	
X	**FMS are provided as an administrative activity.** ***Provide the following information***	
i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
	The Division of DD has a statewide contract with a Vendor Fiscal/ Employer Agent (VF/EA) Financial Management Service provider for payroll services including, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance. A single VF/EA Financial Management Services contractor is responsible for payroll functions. This contractor is also responsible for verifying the citizenship status and background screenings of new workers and making available expenditure reports to Individual. Reimbursement for fiscal management services is an administrative service and not fee for service. The provider is not a governmental entity.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	The Division pays the Vendor Fiscal/Employer Agent (VF/EA) FMS contractor for services provided with general revenue and seeks reimbursement through the MO HealthNet program as an administrative expense. Fiscal management services are provided through a single statewide contract that is re-bid every 3 years. The contractor is a private company. The contractor has a specific rate for each new worker added, each check written, etc. (by transaction). The contractor is paid for these services with general revenue and records of payments will be submitted for 50% reimbursement as administrative service in compliance with 45 CFR 74. Fiscal management services are not reimbursed based on a percentage of the total dollar volume of transactions it processes. The FMS sends a detailed invoice to the Division of DD monthly for the actual cost.	
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
	Supports furnished when the participant is the employer of direct support workers:	
	X	**Assists participant in verifying support worker citizenship status**
	X	**Collects and processes timesheets of support workers**
	X	**Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
	X	**Other**

		Specify: The Fiscal Management Service contractor is available for technical support to the participant/guardian or designated representative in completing paperwork to set up as an employer, completing paperwork for each new worker/employee, and facilitates background checks for all new workers**.** ~~**for the family; the self directed coordinator or service coordinator may also help with these functions.**~~ The Fiscal Management Service contractor maintains ~~**an electronic telephone call-in system to record worker time and**~~ an internet web-portal where worked time can be recorded. The participant/guardian or designated representative, the employees and staff at Regional Offices, and ~~**services**~~***support*** coordinator have access to the secure web-based system to view payment information. Individual/guardians or designated representatives can view total amounts authorized, payments made to workers, and balances. Workers can view current payroll information as well as YTD. Regional office staff and ~~**services**~~***support*** coordination staff can also view authorized amounts, payments, and balances.
	Supports furnished when the participant exercises budget authority:	
	☐	**Maintains a separate account for each participant's participant-directed budget**
	☐	**Tracks and reports participant funds, disbursements and the balance—of participant funds**
	☐	**Processes and pays invoices for goods and services approved in the service plan**
	X	**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
	☐	**Other services and supports** *Specify*:
	Additional functions/activities:	
	☐	**Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
	X	**Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
	X	**Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
	☐	**Other** *Specify:*
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	
	Oversight of the Financial Management Service entities: a) Individual Directed Services are prior-authorized by the local Regional Office on a ~~**monthly or**~~ yearly basis based on the ~~**services**~~***support*** plan. ~~**Unit**~~ ***Dollars*** authorizations are sent to the financial management service provider (FMSP) by Central Office on a daily basis (M-F) based	

on the regional office authorizations. Employees input delivered services ~~through a telephone call-in system, or~~ by entering time through the internet on the FMSP's web-***portal or faxing paper timesheets***. Regional Office staff has access to review information that is input. ~~Employers~~***Individuals/designated representatives*** also have access to the system to approve services and to review their account of authorized and delivered services/dollars. The FMS provider pays workers by direct deposit or a manual check, and calculates, files reports and pays taxes that are due. Employee pay stubs reflecting withholdings from gross payroll are available on-line or sent by regular mail, if requested, to the employee each pay period.

~~**The FMSP prepares payroll reports of payroll-related activity for the employer. A Payroll Register Report, generated per payroll period, quarterly, and year-to-date formats, provides itemized reporting of wages for each employee, total payments, total dollar amounts paid on behalf of each participant employer, service units provided, accrued expenses, and administrative costs. These reports are made available to Regional Offices via the web, or through e-mail. A monthly payroll allocation report is generated by region for each employee providing self-directed services. A Payroll Liability Reimbursement report indicates total costs for each pay period by type of transaction based on negotiated rates. The FMSP provides a report of all project activities to the Division of DD covering for the entire calendar year. This report is due to the Division of DD by January 30 of the following year. The Regional Office reconciles their payment records and escrow account balances. From the data, the Regional Offices' system calculates the unit cost of services and bills the services as waiver services to MO HealthNet. Regional Offices are Organized Health Care Delivery Systems (OHCDS). The FMSP website data bases have built in safety notices that are available to service coordinators and self-directed coordinators if billing is not consistent with the authorization.**~~

The FMS maintains a web portal for the employer. The web portal generates live time reports per payroll expenditures, which itemizes reporting of wages for each employee, total payments, total dollars amounts paid on behalf of each participant. For individuals/designated representatives who do not have internet access reports are sent monthly by mail. These reports are made available to Regional Offices and support coordinators. Additionally the FMSP's processes and systems have quality controls that ensure accurate and appropriate billing. These include system "flags" that identify over-authorizations, duplicate services, duplicate individuals and correct codes/authorizations. This ensures that units billed will not exceed state Medicaid maximums, duplicate billing for same services, and employees only enter billing for authorized services.

b) Participant services are monitored by the Targeted Case Management Entity ~~service~~ ***support*** coordinator. If concern is noted, the quality enhancement leadership team is asked to conduct a further review.

DMH Central Office also monitors the FMSP to ensure contracted activities in support of self-directed services are completed in an Individual centered, timely, and accurate manner. The FMSP also follows their own internal quality assurance plan to meet accounting controls and performance standards including communications, payroll processing, and reporting. Additionally, the FMSP arranges for an annual external CPA agency audit to insure financial internal controls are followed. This report is shared with Individual for whom the FMSP is providing contracted services.

c) Monitoring by the ~~service~~ ***support*** coordinator is quarterly, unless there is reason to monitor more frequently. The FMS contractor, as the agent for the participant/guardian or designated representative, receives all correspondence from federal, state and local employment-related tax and insurance entities and continuously monitors for problems. The FMSP shall make

available all records, books and other documents related to the contract to DMH, its designee, and/or the Missouri State Auditor in an acceptable format, at all reasonable times during the contract period and for three years after the contract termination. The Missouri's State Auditor's Office routinely reviews all programs for problems when auditing each Division Regional Office and Central Office operations.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

X	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
	~~service~~ ***Support*** coordinators, with technical assistance from the regional office self-directed coordinators (as needed), inform individuals of the option of self directing services. The Support coordinator assesses the individual's needs, and assures services are prior authorized by the regional office. The ~~service~~ ***support*** coordinator ensures the ~~service~~ ***support*** plan identifies any risks, and describes action to protect the individual's health and safety. The ~~service~~ ***support*** coordinator can assist the individual in understanding and transitioning services to self-direction.
X	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-1/C-3 (check each that applies):

	Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	~~**Support Broker**~~	~~**X**~~
	Personal Assistant	X
	Community Specialist	X

☐	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one)*.

X	**No. Arrangements have not been made for independent advocacy.**
○	**Yes**. Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service

delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

If an individual voluntarily requests to terminate individual direction in order to receive services through an agency, the ~~service~~ ***support*** coordinator will work with the individual or legal representative to select a provider agency and transition services to the agency model by changing prior authorizations based on the individual's needs. The ~~service~~ ***support*** coordinator and other staff with the Regional Office will make every effort for the transition to be smooth and to ensure the individual is not without services during the transition. If SDS is terminated, the same level of services will be offered to the individual through a traditional agency model.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the planning team determines the health and safety of the individual is at risk, the option of self-directing may be terminated. The option of self-directing may also be terminated if there are concerns regarding the participant/guardian or designated representative's willingness to ensure employee records are accurately kept, or if the participant/guardian or designated representative is unwilling to supervise employees to receive services according to the plan, or unwilling to use adequate supports or unwilling to stay within the budget allocation***; The participant/guardian or designated representative has been the subject of a Medicaid audit resulting in sanctions for false or fraudulent claims under 13 CSR 70-3.030.***

Before terminating self-direction options, the ~~service~~ ***support*** coordinator and other appropriate staff will first counsel the individual or legal representative to assist the participant or legal representative in understanding the issues, let the participant or legal representative know what corrective action is needed, and offer assistance in making changes. If the individual/guardian or designated representative refuses to cooperate, the option of self directing may be terminated. However, the same level of services would be offered to the individual through an agency model.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		~~**200**~~ ***335***
Year 2		~~**220**~~ ***345***

Year 3		~~**240**~~ ***355***
Year 4 (only appears if applicable based on Item 1-C**)**		~~**250**~~ ***365***
Year 5 (only appears if applicable based on Item 1-C**)**		~~**260**~~ ***375***

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:
X	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

X	**Recruit staff**
☐	**Refer staff to agency for hiring (co-employer)**
☐	**Select staff from worker registry**
X	**Hire staff (common law employer)**
X	**Verify staff qualifications**
X	**Obtain criminal history and/or background investigation of staff** Specify how the costs of such investigations are compensated:
	Division of DD Regional Offices pay the costs. The FMSP obtains the background checks.
X	**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
X	**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
X	**Determine staff wages and benefits subject to applicable State limits**
X	**Schedule staff**
X	**Orient and instruct-staff in duties**
X	**Supervise staff**
X	**Evaluate staff performance**
X	**Verify time worked by staff and approve time sheets**
X	**Discharge staff (common law employer)**

▱	**Discharge staff from providing services (co-employer)**
☐	**Other** Specify:

b. Participant – Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

X	**Reallocate funds among services included in the budget**
X	**Determine the amount paid for services within the State's established limits**
X	**Substitute service providers**
X	**Schedule the provision of services**
X	**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
X	**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
X	**Identify service providers and refer for provider enrollment**
▱	**Authorize payment for waiver goods and services**
X	**Review and approve provider invoices for services rendered**
X	Other Specify: ***The individual and/or designated representative approve self-directed employee electronic timesheets for services rendered by use of the FMSP web portal, or by providing signatures on paper timesheets.***

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

For an individual who is self-directing their services, the planning team determines needs based on gathered assessments, such as the Support Intensity Scale. The participant and their planning team identify how they best meet the assessed needs. The team identifies how these needs can be met through informal supports and other sources. Any needs that cannot be met through these means will constitute the waiver individual budget.

The Utilization Review process reviews the budget along with the ~~service~~ ***support*** plan to ensure the level of need reflected in the budget is documented in the ~~service~~ ***support*** plan and that services and amounts of service requested are necessary and consistent with the level of services other individuals who have a similar level of need receive. Historical costs and prior utilization data are also used to project costs and develop the budget. When an annual plan and budget are being renewed, historical costs and prior utilization data become the basis for calculating the new

budget.

The ~~participant~~ ***individual*** is notified in writing of the approved budget and plan. The notice includes appeal rights should a individual disagree with the outcome. This process, which is in state regulation, is explained to Individuals by the ~~service~~ ***support*** coordinator and is available to the public from the State's DMH web-site.

Any time an individual's needs change, the ~~service~~ ***support*** plan can be amended and a new budget can be prepared. If the new budget results in increased level of funding, the service plan and budget will be reviewed through the Utilization Review process before final approval is granted. If an increase in service are needed immediately, an immediate increase can be approved out of the annual budget by the individual or their representative. The team must then meet to determine if an increase in the annual budget is necessary. The person centered planning process including the budgeting process is explained to Individual by the ~~service~~ ***support*** coordinator. Information on the person centered planning process and the Utilization Review process which is in state regulation, are available to the public from the State's DMH web-site.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The method used to determine the individual budget is as follows. Needs of the individual are identified in the ~~service~~ ***support*** plan. The individual along with the planning team determines how the needs can be best met through natural supports, or paid supports and a budget is drafted to meet the individual's needs.

The budget and ~~service~~ ***support*** plan is reviewed by the Utilization Review (UR) Committee. UR considers the budget request in comparison with the level of funding that is approved for other Individual with similar needs and either recommends the Regional Office Director approve the budget or approve the budget with changes.

The ~~participant~~ ***individual*** is notified in writing of the approved budget and ~~service~~ ***support*** plan. The ~~service~~ ***support*** plan has to be signed by the individual or guardian to be implemented. The notice includes appeal rights should a participant disagree with the ~~service~~ ***support*** plan and budget.

The written notice includes information on the ~~participant's~~ ***individual's*** right to a fair hearing and offers help with the appeal process. They may first appeal to the Regional Director. If they are dissatisfied, they have appeal rights through both the Departments of Mental Health and Social Services. While Individual are encouraged to begin with the Department of Mental Health's hearing system, they may skip this hearing process and go directly to the Department of Social Service, MO HealthNet Division (Single State Medicaid Agency) hearing system.

Individual/guardians or designated representatives may request changes to budgets as needs change. For example, they may authorize more services be provided in one month and less in another month. Or, if needs increase, they may request additional services. When additional services are requested, the budget must be approved through the UR process. If an increase in

services are needed immediately, an immediate increase can be approved out of the annual budget by the individual or their representative. The team must then meet to determine if an increase in the annual budget is necessary.

All Regional Offices administer the UR process according to state regulation. Individual/guardians or designated representatives served by the Division of DD and providers are provided information on the UR process.

iv. Participant Exercise of Budget Flexibility. *Select one:*

X	**Modifications to the participant directed budget must be preceded by a change in the service plan.**
○	**The participant has the authority to modify the services included in the participant directed budget without prior approval.** Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Services are prior authorized on a ~~**monthly or**~~ yearly basis based on the needs and history of the individual. Individuals/guardians and designated representatives are informed of the amount of service that may be provided within that authorized period. ~~**The FMSP provides monthly utilization reports. The FMSP also alerts service coordinators and regional office self-directed support coordinators if individuals go above or below their authorizations.**~~***During the course of service implementation the individual, or if applicable, the designated representative provides a monthly services summary to the support coordinator.***

The ~~**service**~~ ***support*** coordinator during service monitoring***, on at least a quarterly basis and more frequently as needed,*** is responsible to ensure that services are being delivered as they are authorized. If services are being underutilized, ~~**service**~~ ***support*** coordinator will seek to determine the reason for under utilization and will ensure the individual's health and safety are not at risk. The ~~**service**~~ ***support*** coordinator is responsible for ensuring the individual has the necessary support to recruit, schedule and supervise employees and will assist the individual in accessing help as needed. ***A support broker assessment used to determine what supports are needed.***
If an individual is at risk of exceeded the budget authorization, the support coordinator will counsel the individual and document within the monitoring system. The Regional Office self-directed support coordinator will help create an improvement plan if needed. Also as part of

the services approval process, the FMSP has a system that tracks real time service utilization for each individual. This is to ensure that only services authorized are billed.
The FMSP has safeguards and notification built in their system with alerts to the ~~service~~ ***support*** coordinator and self-directed coordinator if an individual goes over authorizations. ***The FMSP posts real-time self-directed services allocation and usage on a secure, password protected website for the benefit of individuals wo are self-directing so they can keep track of budget utilization to date and amounts remaining in their allocation. This can be viewed by the individual, designated representative, support coordinator and regional office designees. For individuals who self-direct an services and utilize paper timesheets for their staff, the FMSP send out a monthly spending summary. If it is determined that the individual is at risk of exhausting budget allocation a support broker can be added to provide information and assistance to help the individual better manage the day to day activities of self-directing. If the issue cannot be resolved, the team may need to discuss termination of self-directed supports and transitioning to traditional agency provide supports*** ~~**If an individual has been exceeding the budget authorizations, the service coordinator will counsel and document within the monitoring system and follow up with a plan of correction if needed the individual/designated representative to assist with staying within budget and ensure health and safety needs are met. If it is determined that the individual has been exceeding the budgeting authorization then authorizations can be changed to monthly authorizations, assistance of a support broker can be added or the team may need to discuss termination of self-directed supports and transitioning to traditional provider supports.**~~

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Medicaid rights of due process are extended to ~~**persons**~~ ***individuals*** who participate in the DD Comprehensive Waiver. ~~**Participants**~~ ***Individuals*** have the right to appeal anytime adverse decisions are made or actions are taken.

When adverse action is necessary such as termination, reduction of services, suspension of services, etc., the ~~**service**~~ ***support*** coordinator employed by the Division of DD Regional Office or Targeted Case Management Entity is responsible for notifying the participant in writing at least 10 days prior to any action being taken. Individuals have appeal rights through the Department of Mental Health and Department of Social Services, MO HealthNet Division. While not required to do so, ~~**Division of DD Waiver Participants**~~ ***Individuals*** are encouraged to begin with the Department of Mental Health's appeal process. The individual may, however, appeal to the MO HealthNet Division, before, during and after exhausting the Department of Mental Health process. However, once the individual begins the appeal process with the Department of Social Services, all appeal rights with the Department of Mental Health end since any decision by the single State Medicaid Agency would supersede a decision by Department of Mental Health.

The individual is informed of the appeal process in the written notice. If the adverse action concerns termination or reduction of services, the individual may request the disputed service(s) be continued until the hearing is held and a decision is made on the appeal. If the result of the agency's decision is upheld, the ~~**Participants**~~ ***Individuals*** may be required to pay for the continued services. If the agency's decision is overturned, the ~~**Participants**~~ ***Individuals*** is not responsible for the cost of services. Copies of written notices of adverse action and requests for a Fair Hearing are kept in the individual's record maintained by the regional office or TCM entity.

Individuals are provided information on rights upon entry to the waiver and annually during the person centered planning process. The division has a brochure individuals are given by ~~**service**~~ ***support*** coordinators. In addition, information is posed on the division's web-site.

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**
X	**Yes**. **The State operates an additional dispute resolution process**

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

(a) The Missouri Department of Mental Health has an appeal process that can be utilized by ~~consumers~~***individuals***. Appeals are directed to the DMH Hearings Administrator in the Office of DMH General Counsel.

The Division of Developmental Disabilities also has a Utilization Review ***Process defined in the Missouri Code of State Regulation (9 CSR 45-2.017)***~~**Directive**~~ that applies to all Regional Offices. The Utilization Process is ***used*** to ensure that ***access to*** ~~**quality**~~ services are fair and consistent statewide, plans reflect individual's needs, levels of services are defined and documented within the outcomes of the plans, and plans meet all requirements. If, through the Utilization Review Process the decision of the Regional Office Director results in the denial, reduction, or termination of a specific service then the individual must be informed in writing at least 10 days in advance of the adverse action, must be given the reason for the action, and must be given information ***regarding*** his/her rights to appeal the decision of the Regional Office Director.

(b) If an individual is notified by a Regional Office that they are ineligible for services or ineligible for continued services they may appeal the decision. (See below appeal process) If an individual is eligible for some services but not for a specific service, the appeal steps are the same (as below) except that the individual must first appeal to the case management supervisor before appealing to the regional office director. The individual must appeal to the case management supervisor in writing or orally within 30 days after being notified that they are ineligible for the specific service.

Appeal Process: The individual must appeal ***to the Regional Office Director*** within 30 ***calendar*** days after ***receipt of*** written notice of their ineligibility ~~**to the Regional Office Director**~~. The individual ***will*** receive the Regional Office Director's decision on the appeal within 10 working days after the ***request for*** appeal is received. If the individual does not agree with the Regional Office Director's decision the individual can, within 30 days after receiving that decision, notify the Regional Office intake or ~~**case management**~~***support coordination*** staff and request that an appeals referee hear ~~**their**~~ ***the*** case. The individual will receive written notice that the Regional Office received their request for an appeal hearing. The appeals referee then notifies the individual in writing with the date, time, and location of the hearing. The notice is given to the individual at least 30 days before the hearing and no more than 60 days after the individual first requested the hearing.

An individual may receive ***documents that relate to their appeal*** without ~~**charge documents that relate to their appeal**~~. The documents shall be furnished to the individual within five (5) working

days after the individual requests the documents. The appeals referee bases his or her decision only on information presented at the hearing. The Regional Office Director must convince the referee that the regional office's denial of services was correct.

During the hearing the individual, the individual's representative, or the Regional Office Director may speak, present witnesses, submit additional information relating to the appeal, and question witnesses. The referee records the hearing and the tape is kept for one (1) year after the hearing and is available for review by the individual or their representative. Within 30 days after the hearing the individual receives written notice of the referee's decision.

If the individual disagrees with the referee's decision he or she may request that the decision be reversed or changed or appealed to the Director of the Department of Mental Health. Within 30 days of the decision, the referee may reverse or change the initial appeal decision at the request of the individual, the individual's representative, or the Regional Office Director.

If the individual appeals to the department director, the individual, the individual's representative, or the Regional Office Director may present new evidence or comment on and object to the hearing decision within ten (10) working days of the individual's notice of appeal. The department director considers evidence contained on the tape recording of the appeals hearing and considers other evidence presented. Within 20 working days after receiving notice of an individual's intent to appeal the department notifies the individual and the Regional Office Director of the department director's decision. That notice is the final decision of the Department of Mental Health.

If the individual disagrees with the decision of the director of the Department of Mental Health he or she may appeal to the Circuit Court, according to Chapter 536 of the Revised Statutes of Missouri (RSMo).

(c.)Individuals can at any point in the Department of Mental Health appeal process appeal to the Department of Social Services, MO HealthNet Division. However, once an appeal is filed with the Department of Social Services, all appeal rights with Department of Mental Health cease since Department of Social Services is the single State Medicaid Agency and any decision through that agency would supersede a decision made by the Department of Mental Health. ~~**Consumers**~~ ***Individuals*** and/or responsible parties are informed this dispute resolution mechanism is not a pre-requisite for a fair hearing.

Appendix F-3: State Grievance/Complaint System

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

○	**No. This Appendix does not apply**
X	**Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

Missouri Department of Mental Health

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

The Office of Constituent Services (OCS) was created in 1997 to serve as an advocate for individuals who receive services from the Department of Mental Health and their families. The office provides support to ~~**consumers**~~***individuals*** and family members who have developmental disabilities, substance abuse problems, and mental illnesses. The main goals of the office are to ensure ~~**consumers**~~***individuals'*** rights are not being violated; to review reports of abuse or neglect; and to provide useful information to ~~**consumers**~~***individuals*** and family members about mental health issues.

(a) Individuals and family members may contact the office about suspected abuse, neglect, violation of rights, or concerns regarding mental health facilities or community providers by calling the toll-free number, completing and mailing a complaint form, sending an email to Office of Constituent Services, or writing to the Department of Mental Health, Office of Constituent Services. ~~**Division of DD Directive Number 3.050 addresses the complaint process summarized below.**~~ Individuals are informed that the DMH complaint resolution mechanism is not a prerequisite or substitute for a fair hearing through the Medicaid Agency.

(b) & (c) When a complaint is received in the Office of Constituent Services the staff notifies the Division of DD's Quality Enhancement Leadership team as soon as the complaint is processed. All complaints received by the Office of Constituent Services are emailed/copied to the Division of DD Quality Enhancement Leadership team. The Office of Constituent Services includes the Consumer Affairs Tracking System (CATS) number on all correspondence for tracking purposes and includes the CATS number in the subject box of the email.

Before the Division of DD is notified of a complaint the Office of Constituent Services checks the Customer Information Management, Outcome and Reporting (CIMOR) System to verify the consumer or service is associated with the Division of DD before forwarding the complaint to the Division of DD.

(1) The designated Division of DD's Quality Enhancement Leadership Team member either emails and/or faxes information regarding the complaint within one working day to designated regional office

and habilitation center staff.

(2) The Regional Office Director/Habilitation Center Superintendent or their designee determines and responds in writing to the Quality Enhancement Leadership Team member within 48 hours of receipt of the complaint. The response must specify immediate action that was taken to assure the consumer's health, safety, and rights.

(3) The Regional Office Director or designee determines in 48 hours if: (i) An Abuse/Neglect investigation is warranted, by identifying the Event Management Tracking system (EMT) number assigned, or (ii) An inquiry is warranted, by identifying the EMT number assigned. (An inquiry is initiated when it is determined the complaint fails to provide enough information to determine whether or not the incident involves or meets the criteria for abuse/neglect). (iii) If there is no suspicion of Abuse or Neglect, the information regarding the complaint is forwarded within 10 working days to the local Quality Enhancement member with information that includes who was contacted, when and how, the response to the contact; any follow-up that was, or is being done; and location of documentation related to the complaint. This information is sent to the local Quality Enhancement member, who reviews the information for completeness. If the local Quality Enhancement member has questions, the response is returned to the Regional Office for clarification. Once the issues are adequately addressed, the complaint is considered resolved. The local Quality Enhancement member forwards the information to the Division of DD central office designated coordinator of telephone complaints, who then forwards the completed information to the Office of Constituent Services within 1 working day.

(iv) If the person is not a DMH consumer or DMH does not have investigative authority and Abuse or Neglect is suspected, the Regional Office /Habilitation Center calls Family Support Division (FSD) if the individual is younger than 18 or Department of Health and Senior Services (DHSS) if the individual is 18 or older. The complaint is considered resolved upon referral to the appropriate investigative authority. (v) A complaint is not considered valid, if there is no apparent violation of a DMH standard, contract provision, rule or statute, or there is no valid concern that a practice or service is below customary business or medical practice. If the complaint is not valid it is considered closed upon receipt of the response.

(4) Follow-up of investigations and inquiries are tracked by the Division of DD through the EMT process. The Quality Enhancement Leadership team member is responsible for assuring that the process for investigations and inquiries is followed, and that the completed information is forwarded to the Division of DD central office designated coordinator of telephone complaints. Once the investigation or inquiry is completed, Office of Constituent Services is notified and the complaint is considered closed.

A complaint is resolved when: a) an investigation or inquiry is completed and descriptive information is entered into EMT; b) all information in (3) above is provided and the issues in the complaint are addressed; c) the complaint is referred to the appropriate investigative authority; or d) the reason the complaint is not a valid concern is explained. Consumers and responsible parties are informed this dispute resolution mechanism is not a pre-requisite for a fair hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

✓	**Yes**. **The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
○	**No**. **This Appendix does not apply** (*do not complete Items b through e).* *If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.*

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

System:
The state has a system for reporting and investigation of critical events or incidents. The system for identifying, reporting, and investigating critical events and incidents is outlined in the Code of State Regulations, the Department of Mental Health Operating Regulations and Division of Developmental Disabilities Directives.

Serious incidents:
In accordance with Department Operating Regulation 4.270 and Code of State Regulation 9 CSR 10-5.200 and 10-5.206, the state requires the reporting and investigation of critical events and incidents by all employees of state facilities and community contracted providers.

Critical events that are required to be reported are;
(A) Death of a consumer suspected to be other than natural causes;
(B) Serious injury to a consumer;
(C) Death or serious injury to a visitor at department state operated facilities;
(D) Death or serious injury to a department employee or volunteer while on duty;
(E) Incidents of abuse/neglect, including abuse/neglect involving death, serious injury and sexual abuse;
(F) Suicide attempt resulting in an injury requiring medical intervention (greater than minor first aid);
(G) Elopement with law enforcement contacted or involved;

(H) Criminal activity reported to law enforcement involving consumer as perpetrator or victim when the activity occurs at a facility. If not at a facility, then the criminal activity is serious (felony, etc.);

(I) Fire, theft, or natural disaster resulting in extensive property damage, loss or disruption of service and;

(J) Any significant incident the facility head, district administrator, provider administration or designee decides needs to be reported.

- ***In addition to the DOR 4.270 list of critical events,***
- ***DMH-DD Staff & Contracted Staff are also required to report the following events:***

- ***All events where there is a report, allegation or suspicion that an individual has been subjected to Misuse of Consumer Funds/Property, Neglect, Physical Abuse, Sexual Abuse or Verbal Abuse. (DOR 2.205)***

- ***All***
  - ***Emergency room visits,***
  - ***Non-scheduled hospitalizations,***
  - ***Deaths of individuals served by DD,***
  - ***Med Errors that reach an individual,***
  - ***Incidents of Falls, The apparent (witnessed, not witnessed or reported) unintentional sudden loss from a normative position for the engaged activity to the ground, floor or object which has not been forcibly instigated by another person.***
  - ***Uses of Emergency Procedures with an individual.***
- ***Emergency Procedures- any restraint/time out used by DMH staff or contracted staff to restrict an individuals' freedom of movement, physical activity, or normal access while in DMH services. If any of the following restraint types or time out occurs as defined they must be reported on an EMT form.***
  - ***Chemical Restraint- a medication used to control behavior or to restrict the individual's freedom of movement and is not a standard treatment for the individual's medical or psychiatric condition. A chemical restraint would put an individual to sleep or render them unable to function as a result of the medication. (A pre-med for a dental or medical procedure would not be reported as a chemical restraint.)***
  - ***Manual Restraint- any physical hold involving a restriction of an individual's voluntary movement. Physically assisting someone who is unsteady, blocking to prevent injury, etc. is not considered a manual restraint.***
  - ***Mechanical Restraints- any device, instrument or physical object used to confine or otherwise limit an individual's freedom of movement that he/she cannot easily remove. (The definition does not include the following: Medical protective equipment, Physical equipment or orthopedic appliances, surgical dressings or bandages, or supportive body bands or other restraints necessary for medical treatment, routine physical examinations, or medical tests; Devices used to support functional body position or proper balance, or to prevent a person from falling out of bed, falling out of a wheelchair; or Equipment used for safety during transportation, such as seatbelts or wheelchair tie-downs; Mechanical supports, supportive devices used in normative situations to achieve proper body position and balance; these are not restraints.)***
  - ***Time Out- removing the individual from one location and requiring them to go***

to any specified area, where that individual is unable to participate or observe other people. Time-out includes but is not limited to requiring the person to go to a separate room, for a specified period of time, the use of verbal directions, blocking attempts of the individual to leave, or physical barriers such as doors or ½ doors, etc. or until specified behaviors are performed by the individual. Locked Rooms (using a key lock or latch system not requiring staff directly holding the mechanism) are prohibited.

- ***All events where there is Law Enforcement involvement when the DMH consumer is either the victim, alleged perpetrator, or law enforcement is support in the event.***
- ***All events that result in disruption of DMH service due to fire, theft or natural disaster; resulting in extensive property damage or loss.***
- ***All events where there is sexual conduct involving an individual and it is alleged, suspected or reported that one of the parties is not a consenting participant.***
- ***All events where there is any threat or action, verbal or nonverbal, which conveys a significant risk of immediate harm or injury and results in reasonable concern that such harm will actually be inflicted.***
- ***All events where the consumer ingests a non food item. Non-food item-an item that is not food, water, medication or other commonly ingestible items.***
- ***All events that result in a need for an individual to receive life saving intervention or medical/psychiatric emergency intervention.***
- ***In addition to the above list State Operated Programs (SOP)/Regional Office staff is required to report the following:***
- ***All events that involve Employee Misconduct as outlined in DOR 2.220***
- ***All events that involve a DMH staff with serious injuries as defined by DOR 4.270. Serious injury an injury that results in the hospital admission of the injured person.***

~~**In addition, all waiver contracted providers are required to report to their regional office incidents of;**~~

- ~~**Choking – which resulted in emergency medical intervention or hospitalization**~~
- ~~**Violation of Client Rights**~~
- ~~**Falls**~~
- ~~**Ingestion of Non food items**~~
- ~~**Physical Altercations (consumer & consumer) & (consumer & non-staff)**~~
- ~~**Possession of a weapon**~~
- ~~**Sexual Conduct- consumer/non-consensual**~~
- ~~**Sexual Conduct- consumer & staff**~~
- ~~**Vehicular Accident**~~
- ~~**Consumer self harm, graphic threat of harm and seizures are reported if unusual and not being addressed in the service plan; or if there is an injury, or an allegation/suspicion of abuse or neglect.**~~

The state defines abuse and neglect as:

Neglect- Failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any consumer when that failure presents either imminent danger to the health, safety or welfare of a consumer, or a substantial probability that death or physical injury would result.

Misuse of funds/property- The misappropriation or conversion for any purpose of a consumer's funds or property by an employee or employees with or without the consent of the consumer or the purchase of property or services from a consumer in which the purchase price substantially varies from the market value.

Physical abuse- An employee purposefully beating, striking, wounding or injuring any consumer; in any manner whatsoever, an employee mistreating or maltreating a consumer in a brutal or inhumane manner; or an employee handling a consumer with any more force than is reasonable for a consumer's proper control, treatment or management.

Verbal abuse- an employee making a threat of physical violence to a consumer, when such threats are made directly to a consumer or about a consumer in the presence of a consumer.

Sexual abuse- Any touching, directly or through clothing, of a consumer by an employee for sexual purpose or in a sexual manner. Sexual abuse: Any touching, directly or through clothing, of a consumer by an employee for sexual purpose or in a sexual manner. This includes, but is not limited to: 1. Kissing; 2. Touching of the genitals, buttocks, or breasts; 3. Causing a consumer to touch the employee for sexual purposes; 4. Promoting or observing for sexual purpose any activity or performance involving consumers including any play, motion picture, photography, dance, or other visual or written representation; 5. Failing to intervene or attempting to stop inappropriate sexual activity or performance between consumers; and/or 6. Encouraging inappropriate sexual
activity or performance between consumers.
~~**Sexual abuse- Any touching, directly or through clothing, of a consumer by an employee for sexual purpose or in a sexual manner.**~~

Who must report:

- ***Contracted providers of DD services immediately notify the Department with a written or verbal report of all events of death, abuse, neglect or misuse of consumer funds/property or critical events If a verbal report either by phone or in person is given, the contracted provider must send a completed event report form to the Department the next working day. All other events meeting the reporting criteria must be reported by the next business day.***
- ***The Code of State Regulations (9CSR 10-5.200) requires that any director, supervisor or employee of any residential facility, day program or specialized service, that is licensed, certified or funded by the Department of Mental Health immediately file a written complaint if that person has reasonable cause to believe that a consumer has been subjected to abuse or neglect while under the care of a residential facility, day program or specialized service.***
- ***For all Department employees, complaints of abuse, neglect, or misuse funds/property shall be reported and investigated as set out in Department Operating Regulation 2.205 and 2.210. These reports shall be entered into the Event Management Tracking System (EMT) database within 24 hours or by the end of the next working day after the incident occurred, was discovered, or the notification was received.***

Timeline:
All death, suspicions or complaints of abuse and neglect, and critical events shall be reported immediately. All other events meeting the reporting criteria must be reported by the next business day.

Method of reporting:
These events may be submitted in writing or verbally reported to a DD Responsible State Oversight Organization and Central Office employees. Any verbal report must be followed up with a written report form. There is a standardized Event Report Form.
~~**Who must report:**~~
- ~~**Contracted providers of DD services notify the Department with a written or verbal report of all required incidents immediately unless otherwise specified on form DMH 9719 B. If a verbal report either by phone or in person is given, the contracted provider must send a completed report on form DMH 9719 B to the Department the next working day.**~~
- ~~**The Code of State Regulations (9CSR 10-5.206 and 9CSR 10-5.200) requires that any director, supervisor or employee of any residential facility, day program or specialized service, that is licensed, certified or funded by the Department of Mental Health immediately file a written complaint if that person has reasonable cause to believe that a consumer has experienced an incident affecting the health, safety or welfare of a consumer; or has been subjected to abuse or neglect while under the care of a residential facility, day program or specialized service.**~~
- ~~**For all Department employees, complaints of abuse, neglect, or misuse funds/property shall be reported and investigated as set out in Department Operating Regulation 2.205 and 2.210. These reports shall be entered into the Event Management Tracking System (EMT) database within 24 hours or by the end of the next working day after the incident occurred, was discovered, or the notification was received.**~~

~~**Timeline:**~~
~~**All serious incidents including suspicions of abuse and neglect shall be reported immediately.**~~

~~**Method of reporting:**~~
~~**These incidents may be submitted in writing or verbally reported to DD Regional Office and Central Office employees. Any verbal report must be followed up with a written report form. There is a standardized Community Event Form.**~~

Processing of reports:
- ***Event reports are forwarded to the head of the facility, day program or specialized service, and to the DD Responsible State Oversight Organization facility. All reports of events are processed through the DD Responsible State Oversight Organization. The DD Responsible State Oversight Organization assures proper notification of Law Enforcement (when required), Division of Health and Senior Services (when required) and Children Division (when required). If a report of suspected abuse and neglect is received, the DD Responsible State Oversight Organization designated employee is also responsible for notifying the complainant and parent/guardian.***

- ***The DD Responsible State Oversight Organization requests an investigation through the Department of Mental Health centralized Investigations Unit for all allegations of: Physical Abuse, Verbal Abuse, Neglect, Misuse of Consumer Funds/Property, and Sexual Abuse.***
~~**Event reports are forwarded to the head of the facility, day program or specialized service,**~~

~~**and to the DD regional office. All reports of incidents are processed through the Regional Office. The Regional Office assures proper notification of Law Enforcement (when required), Division of Health and Senior Services (when required) and Children Division (when required). If a report of suspected abuse and neglect is received, the DD Regional Office designated employee is also responsible for notifying the complainant and parent/guardian.**~~

- ~~**The Regional Office requests an investigation through the Department of Mental Health centralized Investigations Unit for all allegations of: Physical abuse, Verbal Abuse, Neglect, Misuse of Client Funds/Property, and Sexual Abuse.**~~
- In the case of a death the Department of Mental Health notifies the Executive Director of Missouri Protection & Advocacy Services via e-mail of all consumer deaths that involve any or all of the following:
  a. Death resulting from a consumer being restrained and/or secluded;
  b. Death resulting from suicide;
  c. Death deemed suspicious for abuse or neglect;
  d. Any unexpected death; or
  e. Death with unusual circumstances.

Information provided to Missouri Protection & Advocacy Services via e-mail to the Executive Director includes:
a. Consumer's name;
b. Consumer's guardian, if one is appointed;
c. Contact information for guardian;
d. Consumer's Social Security Number;
e. Consumer's date of birth;
f. Consumer's date of death

DD Responsible State Oversight Organization Directors, or designated staff, are required to report such deaths to their Division Directors (for community deaths) or the Director of Facility Operations (state operated) within 24 hours of notification of death.

~~**Regional Office Directors, or designated staff, are required to report such deaths to their Division Directors (for community deaths) or the Director of Facility Operations (state operated) within 24 hours of notification of death.**~~

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Training and information:
o ***Support*** ~~**Service**~~ Coordinators annually provide training and education by reviewing a Client Rights brochure with consumers and guardians. The brochure specifies rights consumers receiving services through the Division of DD have under Missouri state law (Sec. 630.15, RSMo.) The brochure also informs consumers and their parents or guardians, they can contact the DMH Office of Constituent Services if they think they are being abused, neglected, or have had rights violated. Contact information includes e-mail address, a toll-free phone number and a toll phone number, fax number, and mailing address. ***Support*** ~~**Service**~~ Coordinators also obtain annually a signed Client's Rights Receipt to demonstrate rights information was provided to the consumer or legal guardian.

o The Missouri DMH has a web site www.dmh.mo.gov which provides consumers and families a link to the Office of Constituent Services where information about consumer rights, detecting and reporting abuse & neglect, the abuse/neglect definitions, and the Reporting and Investigation process which includes contact information. The DMH Client Rights brochure and other information regarding consumer rights and abuse/neglect is posted on this web site at http://dmh.mo.gov/constituentservices/index.htm The site also has a consumer safety video at this site which discusses abuse and neglect and the reporting and investigation process, as well as the brochure Keeping Mental Health Services Safe which is a written version of the video.

o The brochure on Individual Rights of Persons Receiving Services from DD is located at http://dmh.mo.gov/docs/dd/indrights.pdf

Who is responsible:

o Assigned Division of DD or Targeted Case Management entity ***Support*** ~~**Service**~~ Coordinators as discussed above.

o The Division of DD Consolidated Contract requires that each provider gives participants the name, address, and phone number to the DMH Office of Constituent Services. Each consumer is informed that they have the right to contact this office with any complaints of abuse, neglect, or violation of rights.

Frequency of training:

o Annually with each consumer.

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

Entities Receiving Reports:

Each DD Responsible State Oversight Organization receives all written event report forms.

~~**Each Regional Office receives all written community event reports from contracted providers**~~

Report evaluation:

Reports are individually evaluated against set criteria for referral to the appropriate entity. The criteria for referral is as follows:

o ***All of abuse and neglect, and misuse of funds which meet the criteria for reasonable cause are submitted to the Department of Mental Health Central Investigations Unit for investigation.***

~~**All suspicions of abuse and neglect, and misuse of funds are referred to the Department of Mental Health Central Investigations Unit.**~~

o ***If the provider reporting a critical event is responsible for oversight/safety of the consumer, action must be taken to assure the welfare of the consumer. The DD Responsible State Oversight Organization may intervene by placing monitoring processes and staff at the program site, moving individuals from a home and/or terminating contract when appropriate.***

~~**If the provider reporting a critical event is responsible for oversight/safety of the consumer, action must be taken to assure the welfare of the consumer. The Regional Office may intervene by placing monitoring processes and staff at the program site, moving individuals from a home and/or terminating contract when appropriate.**~~

o If there is an allegation of abuse or neglect and the alleged victim is a resident or client of a facility licensed by the Department of Health and Senior Services (DHSS) or receiving

services from an entity under contract with DHSS then phone referral is made DHSS,

- o If there is an allegation of abuse or neglect and the alleged victim is under 18 years of age a phone referral is made to Missouri Department of Social Services/Children's Division
- o If there is alleged or suspected sexual abuse; or abuse and neglect that results in physical injury, or abuse/neglect or misuse of funds/property which may result in criminal charge this is reported to local law enforcement.
- o Missouri Protection and Advocacy is notified by e-mail of all consumer deaths that involve any or all of the following;
  - Death resulting from a consumer being restrained and /or secluded
  - Death resulting from suicide
  - Death deemed suspicious for abuse or neglect
  - Any unexpected death; or
  - Death with unusual circumstance.

Entity responsible for conducting investigations & timeframes:
Upon receipt of a report from the head of the DD Responsible State Oversight Organization, or designee, the Central Investigations Unit assigns an investigator immediately. The assigned investigator initiates contact with the provider to arrange for securing evidence and such other activities as may be necessary.

A final report of the findings is sent to the DD Responsible State Oversight Organization within 30 working days. Upon receipt of the final report the DD Responsible State Oversight Organization Director has 20 calendar days to make a determination. If the determination substantiates abuse or neglect the alleged perpetrator is notified by certified mail. The contracted provider is also notified in writing, required to take appropriate action, and must report an acceptable plan of correction to the DD Responsible State Oversight Organization by a specified date. Further details including the appeals process are described in Department Operating Regulation 2.210 and 2.205.

Informing Participant:
The DD Responsible State Oversight Organization notifies the consumer/guardian and follows up by mail within 10 working days from receipt of an allegation if an investigation has been initiated. Immediately after an investigation is completed and after the effective date of any disciplinary action, the DD Responsible State Oversight Organization provides written notification to the consumer/guardian of the findings of the investigation, a summary of the facts and circumstances and actions taken, except that the names of any employees or other consumers shall not be revealed.

Event data is reported in related performance measures to the Medicaid Agency quarterly.

~~**Upon receipt of a report from the head of the Regional Office, or designee, the Central Investigations Unit assigns an investigator immediately. The assigned investigator initiates contact with the provider to arrange for securing evidence and such other activities as may be necessary.**~~

~~**A final report of the findings is sent to the Regional Office within 30 working days. Upon receipt of the final report the Regional Director has 20 calendar days to make a determination. If the determination substantiates abuse or neglect the alleged perpetrator is notified by certified mail. The contracted provider is also notified in writing, required to take appropriate action, and must report an acceptable plan of correction to the Regional Office**~~

~~**by a specified date. Further details including the appeals process are described in Department Operating Regulation 2.210.**~~

~~**Informing Participant:**~~
~~**The Regional Office notifies the consumer/guardian by mail within 5 working days from receipt of an allegation if an investigation has been initiated. Immediately after an investigation is completed and after the effective date of any disciplinary action, the Regional Office provides written notification to the consumer/guardian of the findings of the investigation, a summary of the facts and circumstances and actions taken, except that the names of any employees or other consumers shall not be revealed.**~~

~~**Incident data is reported in related performance measures to the Medicaid Agency quarterly.**~~

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

Entity for overseeing incident management system:
The Missouri Department of Mental Health, Division of DD is responsible for the oversight of the state's event management system which currently includes one database: Event Management Tracking System (EMT). All critical incidents as defined in G 1-a, investigation findings and timelines are input into the EMT system.

Process of communication:
DD Responsible State Oversight Organization and Support Coordinators are notified of events, including actions taken to protect the health, safety, and rights of the participants and to prevent reoccurrence.

Data collection:
o Designated DD Quality Enhancement Staff analyze aggregate reports of incidents from the EMT database at least quarterly, identifying trends and patterns. These identified trends are incorporated into provider Quality Management Plans, plans of action, and/or the participant's plan of care as indicated.
o Event data is reported in related performance measures to the Medicaid Agency quarterly.
o When there are consistent repetitive concerns or lack of progress on plans, the stakeholders of the provider are notified including the MO HealthNet Division (state Medicaid agency), DMH Licensing and Certification, or the accrediting body (CARF or The Council on Quality and Leadership.)
oAt least annually the Division of DD Quality Enhancement Leadership Team prepares a statewide report which includes quality assurance and improvement recommendations to prevent reoccurrence of patterns, trends and systemic issues. Findings and recommendations are submitted to the Division Director of DD.
~~**Entity for overseeing incident management system:**~~
~~**The operating agency (Missouri Department of Mental Health, Division of DD) is responsible for the oversight of the state's incident management system which currently includes one database: Event Management Tracking System (EMT). All critical incidents as defined in G 1-a, investigation findings and timelines are input into the EMT system.**~~

~~**Process of communication:**~~
~~**SupportService Coordinators receive community event reports from contracted providers, and actions taken to protect the health, safety, and rights of the participants and to prevent reoccurrence.**~~

~~**Data collection:**~~
~~**o Designated Regional Office Quality Enhancement Staff analyze aggregate reports of incidents from the EMT database at least quarterly, identifying trends and patterns. These identified trends are incorporated into provider Quality Management Plans, plans of correction, and/or the participant's plan of care as indicated.**~~
~~**o Incident data is reported in related performance measures to the Medicaid Agency quarterly.**~~
~~**o When there are consistent repetitive concerns or lack of progress on plans of correction, the stakeholders of the provider are notified including the MO HealthNet Division (state Medicaid agency), DMH Licensing and Certification, or the accrediting body (CARF or The Council on Quality and Leadership.)**~~
~~**o At least annually the Division of DD Quality Enhancement Leadership Team prepares a statewide report which includes quality assurance and improvement recommendations to prevent reoccurrence of patterns, trends and systemic issues. Findings and recommendations are submitted to the Division Director of DD.**~~

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

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

○	**The State does not permit or prohibits the use of restraints** Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
✓	**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii:

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

Seclusion (time-out) is allowed in community settings within an approved behavior support plan. Mechanical restraints are not allowed in community settings. Physical restraint and chemical restraint may be permitted. Physical restraint is any manual hold of one person by another which restricts voluntary movement. Physical restraint does not include physically guiding a person during activities such as skill training. Chemical restraint is defined in section 630.005, RSMO, and implemented in Department Operating Regulations are medications administered with the primary intent of restraining a patient who presents a likelihood of serious physical injury to himself or others, not prescribed to treat a person's medical condition. The administration of medication for chemical restraint must be ordered by a physician and the order must include specific instructions for when it may be used. All administration of medication for chemical restraint must be documented in the participant's record. Chemical restraint is administered only in an emergency situation where all other less restrictive interventions are tried first and found ineffective; there are clear indications of imminent harm to the individual or others; and is included in the person's safety crisis plan. If it is used, the consumer cannot be left alone after administration and the affects must be monitored and documented, including intended and unintended effects, side effects, breathing, consciousness, and allergic or other adverse reactions.
~~**Seclusion and mechanical restraints are not used in community settings. Physical restraint and chemical restraint may be permitted. Physical restraint is any manual hold of one person by another which restricts voluntary movement. Physical restraint does not include physically guiding a person during activities such as skill training. Chemical restraint is the use of behavior-modifying drugs prescribed and administered only in the situation of imminent threat of serious physical harm to prevent a participant from injuring self or others; and is used only as part of an approved safety crisis plan.**~~

Physical restraint techniques are limited to those that have been approved by the Division

and determined unlikely to cause undue physical discomfort, pain or injury to an individual and included in the individual's safety crisis plan. Requests for use of crisis management systems other than Mandt or NCI/CPI must be made to the Chief Behavior Analyst of the division in writing, and quarterly analyses of use of the procedures and strategies to eliminate the need must be completed, documentation and submitted to the Chief Behavior Analyst.

In addition to those general concepts, staff is also required to have knowledge of the individual's personal plan which may include additional specific techniques to employ with the individual to avoid situations escalating to physical restraint use. During the use of physical restraint, staff must monitor for intended and unintended effects, including any adverse reactions, the individual's breathing, consciousness, position of limbs.

Physical restraint is used only in an emergency situation where all other less restrictive interventions are tried first and found ineffective; there are clear indications of imminent harm to the individual or others; and is included in the person's safety crisis plan.

~~**Physical restraint that is permitted includes only techniques that are taught in nationally-recognized curricula approved by the Division. Any staff implementing physical restraint techniques must be trained according to an approved curriculum. A component of these curricula includes information regarding de-escalation and re-direction techniques to be used prior to implementation of physical restraint. In addition to those general concepts, staff is also required to have knowledge of the individual's personal plan which may include additional specific techniques to employ with the individual to avoid situations escalating to physical restraint use. Physical restraint is used only in an emergency situation where all other less restrictive interventions are tried first and found ineffective; there are clear indications of imminent harm to the individual or others; and is included in the person's safety crisis plan. During the use of physical restraint, staff must monitor for intended and unintended effects, including any adverse reactions, the individual's breathing, consciousness, position of limbs.**~~

There are prohibited restraint techniques that include physical restraint that interferes with breathing; any technique in which a pillow, blanket or other item is used to cover the face; prone restraint; restraints which involve staff lying or sitting on top of a person; and those that use hyperextension of joints.

~~**The administration of medication for chemical restraint must be ordered by a physician and the order must include specific instructions for when it may be used. All administration of medication for chemical restraint must be documented in the participant's record. Injectable medication cannot be used unless the provider has around-the-clock licensed nurse staffing. Chemical restraint is administered only in an emergency situation where all other less restrictive interventions are tried first and found ineffective; there are clear indications of imminent harm to the individual or others; and is included in the person's safety crisis plan. If it is used, the consumer cannot be left alone after administration and the affects must be monitored and documented, including intended and unintended effects, side effects, breathing, consciousness, and allergic or other adverse reactions.**~~

The Division of Developmental Disabilities supports the use of Positive Behavior Supports concepts. Staff is required to have an introduction to the concepts upon hire and, again, knowledge of the individual's personal plan which, if indicated for the individual, would include the positive supports to be implemented. Positive Behavior Supports are also

designed to mitigate the use of restraint.

The Division of Developmental Disabilities has policies governing the use of restraint, and requires documentation of all uses of restraint~~**in the partcipant's record**~~. In addition, each contracted provider is required to have a policy for its organization around restraint. During Certification surveys, these policies are reviewed for content and compliance with state requirements. In addition, providers who are accredited by a nationally-recognized body must meet the standards outlined by that accrediting body, including any related to the use of restraint. Accredited providers are required to submit their current accreditation report and thus the Division is informed of conformance to those standards.

The division utilizes an Event Management Tracking (EMT) system to track reportable events in accordance with state regulation 9 CSR 10-5.206. An EMT Event Report form is completed by the persons involved in the physical and/or chemical restraint. and these are sent to the DD State Responsible Oversight Organization for entry into the EMT system. Reporting is governed by Missouri administrative rules, known as Code of State Regulations (CSR). The DD State Responsible Oversight Organization reviews the event report and identifies, any unauthorized use of restraints. The service coordinator could also discover an unauthorized restraint was used through Service Monitoring (i.e. in conversation with the individual/staff, review of progress notes, etc.) A service coordinator could determine that the restraint is unauthorized if it is not implemented as outlined in the individual's safety/crisis plan or it is a restraint that is not approved by the Division.
~~**The division utilizes an Events Management Tracking (EMT) system to track reportable events in accordance with state regulation 9 CSR 10-5.206. An EMT Community Event Report is completed by the persons involved in the physical and/or chemical restraint if it results in a reportable event (as listed on the EMT form), signed off on by management staff from the provider then sent to the Regional Office for entry into the EMT system. Reporting is governed by Missouri administrative rules, known as Code of State Regulations (CSR). The Service Coordinator is the designated staff who initially receives the reports and, as first reviewer, can identify unauthorized use of restraints. The service coordinator could also discover an unauthorized restraint was used through Service Monitoring (i.e. in conversation with the individual/staff, review of progress notes, etc.) A service coordinator could determine that the restraint is unauthorized if it is not implemented as outlined in the individual's safety/crisi plan or it is a restraint that is not approved by the Division per the Department Operating Regulation (DOR). If the service coordinator suspects or it is alleged that more force was used than is reasonably necessary when using restraint, they would submit a Community Event Report to be reviewed as suspected/alleged abuse/neglect.**~~

Data is aggregated by region, by provider and by individual, analyzed and reported quarterly to further identify patterns and trends of use, both for consumer and for provider. Data is reported in related performance measures to the Medicaid Agency quarterly.

When a restraint is reported to the DD State Responsible Oversight Organization a designated staff reviews that event to determine if the restraint was a prohibited procedure or if more force than necessary was used in the restraint procedure. If the restraint is determined to be necessary to support the individual, it must be reviewed by the state responsible oversight organization due process committee.

~~**Use of any restraint technique must be reviewed by the Behavior Support Committee, which includes individuals with expertise in behavior intervention strategies. Each**~~

~~**Division of DD Regional Office has a Human Rights Committee that reviews rights issues, including those related to restraints.**~~

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

~~**The Department of Mental Health, Division of DD is responsible for overseeing the use of restraints and ensuring the State's safeguards are followed. The Service Coordinator is the designated staff that initially receives incident reports and, as first reviewer, can identify unauthorized and/or patterns of use. The use of authorized and unauthorized restraints also may be detected during visits with participants and/or service sites minimum quarterly and monthly for participants in residential services, by the service coordinator through services monitoring; the Health Inventory and Regional Office RN review process; Regional Office Quality Enhancement staff; or other Regional Office staff.**~~

State and regional Quality Enhancement Unit staff aggregate event (EMT) data b to further identify patterns and trends. DD State Responsible Oversight Organization will conduct further inquiry if trends or patterns of overuse, unauthorized use and/or ineffective use are noted. Every two years a review by Licensure and Certification (L&C) staff of personnel records is completed as a component of the certification process to assure all staff have received the needed training regarding the individual plan, the basic concepts of Positive Behavior Support, and an approved physical crisis management system such as MANDT or CPI, if restraint is used for the individuals supported by the provider. The L&C staff also reviews policies and procedures for compliance with state requirements.

~~**State and regional QE staff aggregate incident (EMT) data by region, by provider and by individual, analyzed and reported quarterly to further identify patterns and trends of use, both for consumer and for provider. Further inquiry by the Regional Office staff will occur if trends or patterns of overuse, unauthorized use and/or ineffective use are noted. If trends for a participant are identified, the Service Coordinator and planning team address those. If trends by provider are identified, improvement plans are required from the provider by the Regional Office or, if there are incidents of critical status, the Regional Office develops a plan for the provider. Plans are monitored by the Regional Office and if there is no improvement then the provider can be placed on conditional certification status or their contract can be terminated.**~~

~~**Every two years a review by Licensure and Certification (L&C) staff of personnel records is completed as a component of the certification process to assure all staff have received the needed training regarding the individual plan, the basic concepts of Positive Behavior Support, and an approved physical crisis management system such as MANDT or CPI, if restraint is used for the individuals supported by the provider. The L&C staff also reviews policies and procedures for compliance with state requirements. L&C staff also conducts consumer record reviews which can identify unauthorized use of restraint.**~~

~~**Data regarding individuals involved in unauthorized use of restraint is reported to MO Health Net quarterly.**~~ Providers who are placed on conditional certification status are reported to MO HealthNet as it occurs. Any contract termination is reported to MO HealthNet as it occurs.

b. Use of Restrictive Interventions

○	**The State does not permit or prohibits the use of restrictive interventions** Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
✓	**The use of restrictive interventions is permitted during the course of the delivery of waiver services.** Complete Items G-2-b-i and G-2-b-ii.

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

Through requirements of the waiver service definitions and provider contracts staff are required to be trained on the individual's service plan, behavior support plan, and safety/crisis plan prior to implementing any individual restrictive interventions. Any staff utilizing restrictive interventions is required to be trained and competency-tested in MANDT or CPI or other Division approved physical crisis management system.

Any limitations or interventions imposed with regard to the restriction of participant movement, participant access to others, locations or activities, and restriction of participant rights must be reviewed by DD State Responsible Oversight Organization or approved Due Process Review Committee and documented in the individual's plan.
~~**Each staff person is trained on the individual's service plan, behavior support plan, and crisis/safety plan prior to implementing any individual restrictive interventions. Any staff utilizing restrictive interventions is required to be trained and competency-tested in MANDT or CPI or other Division approved physical crisis management system. Staff implementing any individual restrictive interventions are also required to be trained in Positive Behavior Support.**~~

~~**Any limitations or interventions imposed with regard to the restriction of participant movement, participant access to others, locations or activities, and restriction of participant rights must be approved by the Human Rights Committee and documented in the individual's plan.**~~

The state does not allow the use of: ***Physical restraint techniques that interfere with breathing; or any strategy in which a pillow, blanket, or other item is used to cover the individual's face as part of a reactive strategy;***
• Prone restraints (on stomach), restraints positioning the person on their back supine, or restraint against a wall or object;
• Restraints which involve staff lying/sitting on top of a person;
• Restraints that use the hyperextension of joints;
• Any technique which has not been approved by the Division, or for which the person implementing has not received Division-approved training;
Any reactive strategy that may exacerbate a known medical or physical condition, or endanger the individual's life, or is otherwise contraindicated for the individual by medical or professional evaluation;
• Containment without continuous monitoring and documentation of vital signs and status with respect to release criteria;
• Use of any reactive strategy on a "PRN" i.e., "as required" basis. Identification of safe procedures for use during a crisis in an individual's safety crisis plan shall not be considered approval for a restraint procedure on an as-needed basis;
• Aversive stimuli;
• Any procedure used as punishment, for staff convenience, or as a substitute for engagement, active treatment or behavior support services;
• Inclusion of a reactive strategy as part of a behavior support plan for the reduction or elimination of a behavior;

• Reactive strategy techniques administered by other persons who are being supported by the agency;
• Corporal punishment or use of aversive conditioning such as, but not limited to applying painful stimuli as a penalty for certain behavior, or as a behavior modification technique;
• Overcorrection by requiring the performance of repetitive behavior. Examples include, but are not limited to: Contingent exercise, writing sentences, over-cleaning an area, repeatedly walking down a hallway after running;
• Placing persons in totally enclosed cribs or barred enclosures other than crib; and
• Any treatment, procedure, technique or process prohibited by federal or state laws.

~~aversive stimuli/aversive conditioning; any restrictive procedure used as punishment or for staff convenience; corporal punishment; use of totally enclosed cribs or barred enclosures; overcorrection (requiring the performance of repetitive behavior); or any strategy that may exacerbate a known medical or physical condition, or endanger the individual's life, or is otherwise contraindicated for the individual by medical or professional evaluation.~~

The state does allow ***seclusion (***time-out***)***, only after less restrictive techniques have been attempted and found ineffective. ***Seclusion (***time-out***)*** must be described in the behavior support plan; a functional assessment must be completed prior to inclusion in the plan; is time-limited; areas utilized must be safe and comfortable; must be continuously observed by staff; and cannot be locked.

Less restrictive techniques, such as de-escalation, discussion, re-direction, for example, must be attempted before implementing any restrictions. Missouri State Statute outlines consumer rights and communication of any restrictions of those rights. If necessary for the individual's habilitation or therapeutic care, visitors, phone calls, clothing choices, carrying money on their person, television programming or reading materials and outdoor recreation may be restricted. The participant and guardian must be included and informed; and the criteria for removing any restrictions and timelines for reviewing must be documented in the individual's plan. For each episode in which restrictive interventions as outlined in the plan are implemented the following must be documented in the daily observation note: the circumstances and the situation, the less restrictive measures that were attempted, and the implementation of the restrictive intervention. Any restrictions are required to be reviewed by DD State Responsible Oversight Organization or authorized due process review committee. Any participant who has a grievance regarding their rights or a complaint may contact the Department of Mental Health, Office of Constituent Services through the toll-free telephone line, through a dedicated e-mail address or by letter.
~~Less restrictive techniques, such as de-escalation, discussion, re-direction, for example, must be attempted before implementing any restrictions. Missouri State Statute outlines consumer rights and communication of any restrictions of those rights. If necessary for the individual's habilitation or therapeutic care, visitors, phone calls, clothing choices, carrying money on their person, television programming or reading materials and outdoor recreation may be restricted. The participant and guardian must be included and informed; and the criteria for removing any restrictions and timelines for reviewing must be documented in the individual's plan. For each episode in which restrictive interventions as outlined in the plan are implemented the following must be documented in the daily observation note: the circumstances and the situation, the less restrictive measures that were attempted, and the implementation of the restrictive intervention.~~

~~**Any restrictions are reviewed by the Regional Office.Human Rights Committee.**~~

~~**Any participant who has a grievance regarding their rights may appeal to the Department of Mental Health, Office of Consumer Safety. In addition, any complaints can be reported to the Office of Consumer Safety through the toll-free telephone line, through a dedicated e-mail address or by letter, and those complaints are followed-up.**~~

Any of the Division's quality management functions may identify unauthorized use of restrictive interventions.
~~**Any of the Division's quality management functions may identify unauthorized use of restrictive interventions; these functions include quarterly service monitoring; nursing referrals; service plan reviews; complaints process; Licensure and Certification surveys; and quality enhancement reviews.**~~

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:

The operating agency is responsible for the oversight of the state's DMH event management system CIMOR/EMT. All reported events are entered into the DMH Event management tracking system in CIMOR/EMT.

• Support coordinators conduct quarterly reviews of the service plan.

• Division of DD State Responsible Oversight Organization Quality Enhancement staff reviews reported data for patterns and trends quarterly. If a pattern or a trend is discovered, information is collected to ensure strategies are in place that will reduce the use of restrictive supports. The person's plan is reviewed and, if necessary, revised.
• Division of DD state-level Quality Enhancement staff aggregates data quarterly and reports through related performance measures to MO HealthNet. They also provide an annual summary of the EMT data to the Division.
~~**The Service Coordinator is the designated staff who initially receives incident reports and, as first reviewer, can identify unauthorized and/or patterns of restrictions. The use of authorized and unauthorized restrictions also may be detected during visits with participants and/or service sites quarterly/monthly for residential services by the service coordinator through services monitoring; the Health Identification and Nurse Review process; Regional Office Quality Enhancement staff or other Regional Office staff.**~~

~~**The operating agency is responsible for the oversight of the state's DMH incident management system CIMOR/EMT. All reported incidents are entered into the DMH CIMOR/EMT system.**~~

~~**• Service coordinators conduct quarterly reviews of the service plan.**~~

~~**• Division of DD Regional Office Quality Enhancement staff reviews reported data for patterns and trends quarterly. If a pattern or a trend is discovered for an individual consumer, the plan is reviewed and, if necessary, revised. If a pattern or a trend is discovered more broadly for a provider, an improvement plan is put into place.**~~

~~**• Division of DD state-level Quality Enhancement staff aggregates data quarterly and**~~

~~**reports through related performance measures to MO HealthNet. They also provide an annual summary of the EMT data to the Division.**~~

~~**• Licensure and Certification (L&C) staff review the policies and procedures and incidents of providers subject to licensure and certification every two years. In addition, L&C staff do consumer record reviews as a component of the biennial survey, to see required documentation and can pick up unauthorized use of restrictions.**~~
Any participant who has a grievance regarding their rights or a complaint may contact the Department of Mental Health, Office of Constituent Services through the toll-free telephone line, through a dedicated e-mail address or by letter.
~~**• Any participant who has a grievance regarding their rights may appeal to the Department of Mental Health, Office of Constituent Services. In addition, any complaints can be reported to the Office of Constituent Services through the toll-free telephone line, through a dedicated e-mail address or by letter, and those complaints are followed-up.**~~

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:
	~~***Seclusion is not allowed in community settings. Reporting is governed by Missouri administrative rules, known as Code of State Regulations (CSR). The DD State Responsible Oversight Organization reviews the event report and identifies, any unauthorized use of seclusion. The service coordinator could also discover an unauthorized use of seclusion through Service Monitoring (i.e. in conversation with the individual/staff, review of progress notes, etc.)***~~
✓	**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 in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Seclusion (time-out) is allowed in community settings within behavior support plans approved by the division's Chief Behavioral Analyst. Reporting is governed by Missouri administrative rules, known as Code of State Regulations (CSR). The DD State Responsible Oversight Organization reviews the event report and identifies, any unauthorized use of seclusion. The service coordinator could also discover an unauthorized use of seclusion through Service Monitoring (i.e. in conversation with the individual/staff, review of progress notes, etc.

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:

Seclusion (time-out) is allowed in community settings within behavior support plans approved by the division's Chief Behavioral Analyst. A CIMOR-EMT Event Report is completed by the persons involved in the event where seclusion was used. The event report is submitted to the DD Responsible State Oversight Organization for entry and review in the CIMOR- EMT System. If the report reaches criteria for an allegation of abuse or neglect an inquiry would be conducted to establish or rule out reasonable cause. If reasonable cause is established a DMH investigation will be requested.

The Department of Mental Health (Operating Agency) is responsible for methods to detect the unauthorized use of seclusion. Seclusion is considered a prohibited technique unless otherwise in a behavior support plan approved by the division's Chief Behavior Analyst. as outlined in the provider contract, if it occurs it is required to be reported as noted in Missouri administrative rules, known as Code of State Regulations (9 CSR 10-5.206) . The DD State Responsible Oversight Organization will identify the use of seclusion through any of the division's quality management functions.

Appendix G-3: Medication Management and Administration

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

Entity or entities responsible for ongoing monitoring of participant medication regimens:

The entities responsible for monitoring participant medication regimens include the prescribing entities, contracted provider, and the Missouri Division of Developmental Disabilities (DD).

Scope of monitoring The scope of medication monitoring is a holistic approach incorporating reviews by a medical professional of the medications prescribed, participant response and the delivery of their support service. The scope of monitoring incorporates two levels of review beyond the prescribing entity. The provider level includes oversight of all participants' medications and participant response by the provider RN. A second level of review by the Division of DD Regional Office Quality Enhancement RN (QE RN) includes consideration of medication categories including: anti-convulsants, anti-coagulants, and behavior modifying drugs when identifying the sample of cases to receive a full QE nursing review.

Methods for conducting monitoring:

In the event the contractor is providing residential services, the contractor shall provide nursing oversight services for all residential individuals. Nursing oversight shall be provided by Registered Nurses (RNs) licensed and in good standing in the state of Missouri.

Nursing oversight activities shall include, but are not limited to:

a. regular monthly nursing functions specified by the Department for each consumer; The current nursing functions are identified in the community RN manual, which is available on the DMH website.

b. collaboration with designated Department staff in the implementation of statewide health and safety initiatives;

c. review and analysis of event reports for medication errors and injuries; and

d. completion of a Monthly Health Summary for each individual.

~~**All providers of residential services employ a Registered Nurse (referred to as a Community RN) for review and monitoring of participant medications regimen on a monthly basis. This consists of an on-site review of medical records and a face to face evaluation of the participant's health needs including routine and PRN medication, medication effectiveness, participant response, and side effects. The Community RN is required to review all medication error reports as well as hospitalization, significant change in behaviors and any PRN psychotropic drug use, and take necessary action as part of their oversight function. Findings are recorded in the nurse's monthly summary. This summary is shared with the provider management for further planning and intervention as needed and integrated into the monthly review and service plan as appropriate for the participant. The Service Coordinator monitors to assure implementation and resolution of significant findings. Unresolved issues are entered into the Action Planning Tracking System (APTS) for analysis and intervention and tracking of resolution.**~~

~~**All state DD Regional Offices have Quality Enhancement RNs who are responsible for monitoring participants' medication regimens as part of their nursing review which is completed at least annually and anytime there is significant health changes for participants who meet a threshold score on the health inventory tool; all who are entering into residential placement for the first time; and all who may need a nursing consultation. Medication usage for all participants is specifically tracked for the categories of: anti-convulsants, anti-coagulants, behavior modifying drugs and use of Baclofen pumps. In addition, the total number of routine medications per participant is evaluated.**~~

Frequency of monitoring:

All DD Regional Offices have Quality Enhancement RNs who are responsible for monitoring individuals' medication regimens as part of the Health Identification and Planning System (HIPS). The health identification planning process for persons in residential services is completed annually, with significant health changes, and when entering placement for the first time.

~~**Monitoring by the Provider RN is monthly as defined above. Monitoring by the Division of DD Regional Office QE RN is at least annually and anytime there are significant health changes for residential participants who meet a threshold score on the health inventory tool; and all who are entering residential placement for the first time. The Service Coordinator monitors on a monthly basis.**~~

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

The agency responsible for oversight is the MO Department of Mental Health /Division of DD (operating agency). The operating agency monitors medication administration through the Division's Quality Functions for discovery, remediation, and quality improvement.

As part of the Division's Event Management Tracking process, all medication errors that reach the "individual are required to be reported to the DD Responsible State Oversight

organization. A clinical review is completed by a QE RN for all medication errors meeting the division definition of moderate or severe. All clinical review findings and actions are recorded in the Event Management Tracking system. The clinical review is a form of risk mitigation, reducing risk factors associated with the event.
Medication errors where there is a suspicion of abuse, neglect, and/or misuse of funds meeting the criteria for reasonable cause are submitted to the Department of Mental Health Central Investigations Unit for investigation.

During monthly monitoring visits, support coordinators are expected to review documentation to assure all prescribed medications are administered, discovered errors are reported, and adequate supplies of medications are available.

All DD Regional Offices have Quality Enhancement RNs who are responsible for monitoring participants' medication regimens as part of the Health Identification and Planning System (HIPS). The health identification planning process for persons in residential services is completed annually, with significant health changes, and when entering placement for the first time.

During the nursing review medication usage is evaluated. For individuals meeting an inventory score threshold, all medications are analyzed for potentially harmful practices. As part of a review or consultation, the QE RNs are able to evaluate medication usage patterns and drug to drug and drug to food interactions through use of web-based resources such as Cyber-Access and a drug interaction web programs. (CyberAccess is a web-based HIPAA-compliant portal which acts as an electronic health record for Medicaid participants for the state Medicaid agency; medication history can be viewed through this portal.)

The Quality Enhancement RNs also evaluate for the required components of delegation when it applies. All significant findings are addressed through development of an action plan for resolution and monitored by the Support Coordinator. Significant findings requiring action are tracked in the Action Planning Tracking System (APTS) for analysis of trends and patterns at the provider, individual, region, and state level. At least quarterly, Quality Enhancement staff analyzes regional data from the data bases for trends and patterns which are shared with local management for possible follow-up by the Regional Office.

~~**The Regional QE RNs utilize the MO HealthNet (Medicaid agency) Cyber-access program which allows for the monitoring of DD Medicaid recipient's full medication regimen to ensure its appropriateness, types, and usage patterns. It is instrumental in medication management review and assists to guard against over or inappropriate medication use.**~~
~~**The agency responsible for oversight is the MO Department of Mental Health /Division of DD (operating agency). The State monitors medication administration through the Division's Quality Functions for discovery, remediation, and quality improvement.**~~

~~**For events that meet the definition of suspected abuse or neglect, the Department of Mental Health's Central Investigations Unit will complete an investigation. Significant findings are tracked in the Event Management Tracking system (EMT) for analysis during the quarterly and annual data reviews.**~~
~~**During monthly monitoring visits, assigned service coordinators review documentation to assure that all prescribed medications are administered and that adequate supplies of medications are available.**~~

~~**All state DD Regional Offices have Quality Enhancement RNs who are responsible for monitoring participants' medication regimens as part of their nursing review which is completed at least annually and anytime there is significant health changes for participants who meet a threshold score on the health inventory tool; all who are entering into residential placement for the first time; and all who may need a nursing consultation. Medication usage for all participants is specifically tracked for the categories of: anti-convulsants, anti-coagulants, behavior modifying drugs and use of Baclofen pumps. In addition, the total number of routine medications per participant is evaluated. For participants meeting an inventory score threshold, all medications are analyzed for potentially harmful practices. As part of a review or consultation, the QE RNs are able to evaluate medication usage patterns and drug/drug and drug/food interactions through use of web-based resources such as Cyber-Access and a drug interaction web programs. (CyberAccess is a web-based HIPAA-compliant portal which acts as an electronic health record for Medicaid participants for the state Medicaid agency; medication history can be viewed through this portal.)**~~

~~**The Quality Enhancement RNs also evaluate for the required components of delegation when it applies. All significant findings are addressed through development of an action plan for resolution and monitored by the Service Coordinator. Significant findings are tracked in the Action Planning Tracking System (APTS) for analysis of trends and patterns at the provider, consumer, regional, and state level. At least quarterly, Regional Office Quality Enhancement staff analyzes regional data from the data bases for trends and patterns and shares analysis with provider agencies, and coordinate any needed follow-up.**~~

~~**At least annually Quality Enhancement Leadership Team analyzes statewide data for trends and patterns resulting in regional, provider, or state-wide quality initiatives to address identified issues. In addition to event reporting data, the Quality Enhancement Leadership Team will analyze pertinent data from the Event Management Tracking system which tracks incident/injuries/medication errors, abuse and neglect investigations, and mortality reviews; and the Action Planning Tracking system which tracks service monitoring, nurse review, Licensing and Certification reports and other quality management functions, and Self Advocate and Families for Excellence (SAFE) consumer review reports. These data systems can provide specific information in regards to patterns and trend in medication management.**~~

~~**Reports are generated from the APTS program for monitoring; medication error reports are generated from EMT. Incident data is reported in related performance measures to the Mmedicaid agency quarterly.**~~

~~**The Regional QE RNs utilize the MO HealthNet (Medicaid agency) Cyber-access program which allows for the monitoring of DD Medicaid recipient's full medication regimen to ensure its appropriateness, types, and usage patterns. It is instrumental in medication management review and assists to guard against over or inappropriate medication use.**~~

c. Medication Administration by Waiver Providers

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

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

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

In accordance with 9 CSR45-3.070, staff who administer medication or supervise self-administration of medication to participants must be either a licensed physician; licensed nurse; or must be delegated the task of medication administration and supervised by a licensed medical professional. Persons who administer or supervise self- administration of medication to participants must be certified as a Medication Aide through Department of Mental Health or Department of Health and Senior Services (DHSS) before being delegated and performing medication administration tasks.

~~**Participants in residential services who self-administer medication must have a physician's order, must have demonstrated competency for all aspects of self-administering and this must be reflected in their plan of care. Compentencies should be re-evaluated at least annually and with performance concerns. All consumers are encouraged to learn and participate at the highest possible level with administration of their medications however, if an individual requires any portion of medication administration to be completed by employed staff, the provider remains responsible for the oversight of medication administration. Staffs who oversee the participants' administration of medication must be trained and certified meeting the requirements described above in the CSR.**~~

~~**In accordance with the Missouri Nurse Practice Act medication administration is a nursing task and must be completed by a licensed medical professional or be delegated to a non-licensed staff. All delegated medication administration is supervised by a licensed medical professional at an intensity determined by the delegator. To prepare for the delegated task of medication administration, all non-licensed personnel must successfully complete a DMH approved course in medication administration to obtain and remain certified.**~~

~~**Administration of medication through a Gastrostomy or Jejunostomy and Insulin administration requires additional training, delegation, and supervision by a medical professional. For non-licensed personnel, the minimum prerequisite for receiving the additional training and responsibility is successful completion of the DMHor DHSS Level I Medication Aide Certification. Certification does not prepare the individual to administer meds via g-tube or j-tube or administer insulin however, it is a required foundation before additional training and delegation can occur.**~~

~~**Delegating RN's may withdraw delegation at anytime based on their professional judgment / supervision of the non-licensed personnel or the participant's response or stability to medication or treatment.**~~

~~**In accordance with 9 CSR45-3.070, individuals who administer medication or supervise**~~

~~**self-administration of medication to participants must be either a licensed physician; licensed nurse; or must be delegated the task of medication administration and supervised by a licensed medical professional after the individual obtains certification as a DD or Department of Health and Senior Services (DHSS) Level I Medication Aide or Medication Technician as a required prerequisite.**~~

~~**Participants in residential services who self-administer medication must have a physician's order, must have demonstrated competency for all aspects of self-administering and this must be reflected in their plan of care. All consumers are encouraged to learn and participate at the highest possible level with administration of their medications however, if an individual requires any portion of medication administration to be completed by employed staff, the provider remains responsible for the oversight of medication administration. Staff who oversee the participants' self-administration of medication must be trained and meet the requirements described above in the CSR.**~~

~~**Medication administration is a nursing task and must be completed by a licensed medical professional or be delegated to a non-medical staff who meets the requirement of obtaining Medication Aide Certification. All delegated medication administration is supervised by a licensed medical professional at an intensity determined by the delegator. To prepare for the delegated task of medication administration, all non-medical personnel must successfully complete a DMH approved course in medication administration.**~~

~~**Administration of medication through a gastrostomy or jejunostomy and Insulin administration requires additional training, delegation, and supervision by a medical professional. For non-medical personnel, the minimum prerequisite for receiving the additional training and responsibility is successful completion of the DD or DHSS Level I Medication Aide Certification. Certification does not prepare the individual to administer meds via g-tube or j-tube or administer insulin however it is a required foundation before additional training and delegation can occur.**~~

~~**Delegating RN's may withdraw delegation at anytime based on their professional judgment / supervision of the non-medical personnel or the participant's response or stability to medication or treatment.**~~

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

✓	**Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).** *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	In addition to appropriate follow up with medical professionals in response to medication errors, providers are responsible for documenting and reporting medication errors to their designated State Division of DD Regional Office in accordance with Event Reporting regulation 9 CSR10-5.206. In addition, any action taken should be reported. Event reports are entered into the statewide Event Management Tracking System (EMT) data base.
	(b) Specify the types of medication errors that providers are required to *record:*
	In accordance with 9 CSR 10-5.206 Report of Events, providers are required to record any of the following medication error • ***Failure to administer;*** • ***Wrong Dose;*** • ***Wrong Medication;*** • ***Wrong Route;*** • ***Wrong Person;*** • ***Wrong Time;*** ~~**In accordance with 9 CSR 10-5.206 Report of Events, providers are required to record medication errors meeting the policy definitions of:**~~ ~~• **Failure to administer;**~~ ~~• **No physician Order;**~~ ~~• **Wrong Dose;**~~ ~~• **Wrong Medication;**~~ ~~• **Wrong Route;**~~ ~~• **Wrong Person;**~~ ~~• **Wrong Time; and**~~ ~~• **Medication administered with a documented allergy to medication**~~
	(c) Specify the types of medication errors that providers must *report* to the State:
	In accordance with 9 CSR 10-5.206 Report of Events, providers are required to report medication errors meeting the policy definitions of: In accordance with 9 CSR 10-5.206 Report of Events, providers are required to report any of the following medication error types that reach and individual; • ***Failure to administer;*** • ***Wrong Dose;*** • ***Wrong Medication;*** • ***Wrong Route;*** • ***Wrong Person;*** • ***Wrong Time;*** ~~**In accordance with 9 CSR 10-5.206 Report of Events, providers are required to report medication errors meeting the policy definitions of:**~~ ~~• **Failure to administer;**~~ ~~• **No physician Order;**~~ ~~• **Wrong Dose;**~~ ~~• **Wrong Medication;**~~ ~~• **Wrong Route;**~~

	~~• Wrong Person;~~ ~~• Wrong Time; and~~ ~~• Medication administered with a documented allergy to medication.~~ ~~Providers notify the Department with a written or verbal report of all medication errors immediately. If a verbal report either by phone or in person is given, the contracted provider must send a completed report on the required form to the Department the next working day. Individual medication errors are reviewed and addressed by provider administration with their provider RN.~~
○	**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.** Specify the types of medication errors that providers are required to record:

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

Oversight is conducted by the operating agency, Division of DD. In accordance with 9 CSR 10-5.206, medication errors are reported to the DD Responsible State Oversight organization using the standardized Event Report form. These reports are entered into the statewide event database (EMT) and are tracked for analysis of trends and patterns at the provider, consumer, regional, and state level. Division of DD QE RNs also review medication error reports to identify patterns or trends for consumers and/or providers. The reports are also reviewed to ensure appropriate safeguard measures were taken.

If medication errors are noted in the records, the support coordinator may investigate further to ensure the errors were properly reported to the state in accordance with 9 CSR 10-5.206 and that all necessary corrective action was taken.
Quarterly the Division of DD's State Quality Enhancement Unit analyzes data to identify trends or patterns that may require additional actions for the provider, the region, or statewide.
~~**Oversight is conducted by the operating agency, Division of DD. In accordance with 9 CSR 10-5.206, medication errors are reported to the DD regional office using the standardized community event form. These reports are entered into the statewide event database and are tracked for analysis of trends and patterns at the provider, consumer, regional, and state level. Individual event reports are entered into a statewide database for analysis of trends and patterns around medication errors as defined by policy. As with other types of incidents, the Service Coordinator is the first reviewer so patterns can be identified for an individual consumer. Regional Office QE RNs also review medication error reports to identify patterns or trends for consumers and/or providers. The reports are also reviewed to ensure appropriate safeguard measures were taken. Regional Office staff coordinates follow-up where concerns are identified.**~~
~~**As part of service monitoring, service coordinators review provider records of service delivery. If medication errors are noted in the records, the service coordinator may investigate further to will ensure the errors were properly reported to the state in accordance with 9 CSR 10-5.206 and that all necessary corrective action was taken.**~~
~~**It is the provider's responsibility to remediate the individual issues discovered through**~~

~~**the state's quality management functions. It is the role of the Division of DD's Regional Offices and State Quality Enhancement Team to identify trends and develop plans of action to assure remediation through service coordination and Quality Functions. At least quarterly, the Regional Office Quality Enhancement Team reviews regional data in the EMT and APTS data bases for tracking and trending data and coordinates necessary follow-up. By reviewing information in all data systems, trending is completed reviewing types of errors, frequency, by consumer, by staff, by home, or provider.**~~

~~**The state Health and Wellness Coordinator (aggregates data state-wide and by region, on medication errors and reports to Division management, regional offices and MOHealth Net quarterly. This includes the types of errors, identification of providers and consumers with the highest rates of errors, potential problems with medication practices, and recommendations/plans for improvement.**~~

~~**For events that meet the definition of suspected abuse or neglect, the Department of Mental Health's Central Investigations Unit will complete an investigation. Significant findings are tracked in a statewide database for analysis during the quarterly and annual data reviews.**~~

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. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-assurances:

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

i. **Performance Measures**

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed

statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Number and percent of waiver participants who* ~~**are**~~**were** *informed of how to report suspected abuse/neglect/misuse of funds (Number of* ~~***waiver***~~ *participants informed of how to report* ***suspected abuse/neglect/misuse of funds divided by***~~***over the***~~ *number of* ***records reviewed within the identified timeframe*** ~~*waiver participants*~~*)*
Data Source *(Select one) (Several options are listed in the on-line application): Analyzed Collected Data (including surveys, focus group, interviews, etc.)*	
If 'Other' is selected, specify:	

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

Add another Data Source for this performance measure

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*
~~*X*~~ *☐ State Medicaid Agency*	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other

	Specify:

Performance Measure:	*Number and percent of* ***unexplained deaths for individuals with an open episode of care*** ~~***incidents reported within required time frames***~~*. (Number of* ***unexplained deaths of individuals with an open episode of care*** ~~**serious incidents reported within time frames over the**~~ ***divided by*** *number of* ***deaths of individuals with an open episode of care*** ~~**total serious incidents reported**~~*)*
Data Source *(Select one) (Several options are listed in the on-line application: Critical events and incident reports*	
If 'Other' is selected, specify:	

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

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

State:	
Effective Date	

	Specify:

Performance Measure:	*Number and percent of* ***~~incidents~~ EMT system events with a complaint or suspicion of abuse, neglect, misuse of funds or property, reported in the required timeframe. ~~reported in which an inquiry was conducted within required time frames.~~*** *(number of* ***~~incidents~~ events with a complaint or suspicion of abuse, neglect, misuse of funds or property reported in the required timeframe divided by ~~where inquiry indicated was conducted within required time frames over the total~~*** *number of* ***events with a complaint or suspicion of abuse, neglect, misuse of funds or property ~~incidents in which inquiry was indicated~~****)*
Data Source *(Select one) (Several options are listed in the on-line application): Critical events and incident reports*	
If 'Other' is selected, specify:	

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

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*
X Operating Agency	*☐ Monthly*
~~X~~☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and

	Ongoing
	☐ *Other Specify:*

Performance Measure:	*Number and percent of* ***EMT system events where an inquiry was conducted within required timeframes*** ~~***potential incidents of abuse/neglect/misuse of funds in which an investigation was initiated within required timeframes.***~~ *(Number of* ***EMT system events within the identified quarter where an inquiry was conducted within required timeframes divided by***~~***investigations initiated within required timeframes over***~~ ***number of EMT system events within the identified quarter where an inquiry was conducted.*** ~~***the total number of investigations initiated***~~*)*

Data Source *(Select one) (Several options are listed in the on-line application): Critical events and incident reports*

If 'Other' is selected, specify:

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

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*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*

State:	
Effective Date	

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

Performance Measure:	*Number and percent of* ***~~investigations that were substantiated for abuse/neglect~~ EMT system events where an investigation was initiated within required timeframes.*** *(Number of* ***EMT system events where an investigation was initiated within required timeframes divided by ~~substantiations of abuse and neglect ÷Total number of abuse/neglect investigations conducted for all waiver participants~~ Number of EMT system events where an investigation was initiated****)*
Data Source *(Select one) (Several options are listed in the on-line application): Critical events and incident reports*	
If 'Other' is selected, specify:	

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

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

State:	
Effective Date	

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

Performance Measure:	~~***Proportion of deaths which meet mortality review criteria for which the reviews are completed within identified timeframes (# of deaths reviewed meeting timeframe over the total # of deaths reviewed for waiver participants.)***~~
Data Source *(Select one) (Several options are listed in the on-line application): Critical events and incident reports*	
If 'Other' is selected, specify:	

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

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

State:	
Effective Date	

	Specify:

Performance Measure:	~~***Number of substantiated cases of abuse involving unauthorized use of restraint. (Number of substantiated cases of abuse involving unauthorized use of restraint over the number of substantiated cases of abuse)***~~

Data Source *(Select one) (Several options are listed in the on-line application): Critical events and incident reports*

If 'Other' is selected, specify:

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

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

Performance Measure:	~~***Number and percent of waiver participants in residential services with no medication errors reported (number of participants in residential services with no medication errors over the total number of participants in residential services)***~~

Data Source *(Select one) (Several options are listed in the on-line application): Critical events and incident reports*

If 'Other' is selected, specify:

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

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*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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.

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

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

Performance Measure:	***Number and percent of moderate or severe med errors with a clinical QE review. (Number of moderate and severe med errors from EMT with a clinical QE review divided by Number of moderate and severe med errors from EMT)***		
Data Source *(Select one) (Several options are listed in the on-line application):* ***Critical events and incident reports***			
If 'Other' is selected, specify:			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	***X*** *100% Review*
	X *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

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*
X *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	***X*** *Quarterly*
☐ *Other Specify:*	***X*** *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	***Number and percent of choking events with a clinical QE review. (Number of choking events entered in EMT with a clinical QE review divided by Number of choking events entered in EMT)***
Data Source *(Select one) (Several options are listed in the on-line application):* ***Critical events and incident reports***	
If 'Other' is selected, specify:	

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

Performance Measure:	***Number and percent of individuals meeting the Division's established fall threshold for the identified quarter with documented follow-up. (Number of individuals with documented follow-up when meeting the Division's established fall threshold in the identified quarter divided by Number of individuals meeting the Division's established fall threshold in the identified quarter)***

Data Source *(Select one) (Several options are listed in the on-line application):* ***Trends, remediation actions proposed/taken***

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*	*X100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*✓ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	***Number and percent of individuals meeting the Division's established emergency procedure threshold for the identified quarter with documented follow-up. (Number of individuals with documented follow-up when meeting the emergency procedure threshold in the identified quarter divided by number of individuals meeting the emergency procedure threshold in the identified quarter)***
Data Source *(Select one) (Several options are listed in the on-line application):* ***Trends, remediation actions proposed/taken***	
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*	*X 100% Review*
	X Operating Agency	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	✓ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

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*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	***Number and percent of individuals meeting the Division's physical altercation threshold for the identified quarter with documented follow-up. (Number of individuals with documented follow-up when meeting the physical altercation threshold in the identified quarter divided by Number of individuals meeting the physical altercation threshold in the identified quarter***
Data Source *(Select one) (Several options are listed in the on-line application):* ***Trends, remediation actions proposed/taken***	
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*	*X 100% Review*
	X Operating Agency	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	✓ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

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*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

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

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

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

Performance Measure:	***Number and percent of providers assessed through a Provider Relations (PR) review with policy and procedures on use of restrictive interventions. (Number of providers assessed through a PR review during the identified quarter with policy and procedures on use of restrictive interventions divided by Number of providers assessed through a PR review during the identified quarter)***		
Data Source *(Select one) (Several options are listed in the on-line application):* ***Provider Performance Monitoring***			
If 'Other' is selected, specify:			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

Add another Data Source for this performance measure

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*
X *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	***X*** *Quarterly*
☐ *Other Specify:*	***X*** *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	***Number and percent of events entered into the EMT system where a Prohibited Procedure was not used. (Number of events entered into the EMT system where a prohibited procedure was not used during the reporting period divided by Number of events entered into the EMT system during the reporting period.)***		
Data Source *(Select one) (Several options are listed in the on-line application):* ***Critical Events and Incident Reports***			
If 'Other' is selected, specify:			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

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

Add another Data Source for this performance measure

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*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other Specify:*	*X Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

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.

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 individuals whose ISP addresses their health needs. (Number of individuals whose ISP addresses their health needs divided by Number of individuals reviewed in the sample)***
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record Reviews, off-site***	
If 'Other' is selected, specify:	

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

Add another Data Source for this performance measure

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*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	***Number and percent of individuals whose health needs are being addressed according to support monitoring. (Number of individuals without an entry relating to health in support monitoring divided by Number of individuals participating in the waiver)***
Data Source *(Select one) (Several options are listed in the on-line application):* ***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*	*X100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	✓ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

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*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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. In addition, provide information on the methods used by the State to document these items.*

Individual problems are referred to the Regional Office Assistant Director as they are received or substantiated by staff in the Office of Consumer Safety. All reported incidents, deaths, or complaints are tracked and reported to the Regional Office immediately. A response to the report must be included in the tracking system. More serious reports~~Reports~~found suspicious for abuse/neglect are investigated by staff from the Department of Mental Health. Remediation is a coordinated effort by Central Office staff, Regional Office staff, and other concerned parties that could include law enforcement or other state Departments. Less serious reports Other types of complaints and incidents are resolved by the Regional Office with the assistance of the ~~**service**~~ ***support*** coordinator and other staff that could include Central Office management ~~**staff**~~. The state routinely monitors and evaluates tracking systems to ensure all reported incidents/complaints have been remediated through quarterly reporting to Division management and Regional Office Directors.

Quarterly data for all incidents entered into the statewide tracking system are reviewed to identify outliers for follow up and response by the Regional Office. Responses are monitored at the state level to ensure action has been taken.

Each quality management function has its own guideline, designated staff, and process of identification, communication, and remediation. This allows for timely evaluation of information and development of an appropriate action plan for the individual issue(s) identified.
Through the function of event reporting DD staff is designated to review each medication error report to assure that the action taken by the provider will reduce the risk of re-occurrence. In addition any medication errors meeting the Division definition of moderate or severe medication error receive a clinical review by the Regional QE RN which is documented in the Event Management Tracking System.

ii. **Remediation Data Aggregation**

	Responsible Party *(check*	**Frequency of data**

	each that applies):	**aggregation and analysis** *(check each that applies)*
	☐ **State Medicaid Agency**	☐ **Weekly**
	X **Operating Agency**	☐ **Monthly**
	X **Sub-State Entity**	X **Quarterly**
	☐ **Other** Specify:	X **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. **Timelines**

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

X	**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

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- 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 QIS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS 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.

H.1 Systems Improvement

a. System Improvements

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

Overview

The Division's quality management strategy includes multiple real-time methods of feedback and information gathering in addition to periodic inspection processes. ~~**Consumers**~~ ***Individuals*** (program participants) and community members are in active roles. The system utilizes quality improvement processes such as data analysis, tracking, and trending. Data bases are in place for gathering information and subsequent analysis and trending.

In addition to the statewide quality management functions completed by the Division of Developmental Disabilities (DD), there are functions completed by the Department of Mental Health and other state agencies including Department of Social Services/MO HealthNet Division, the Medicaid administrative agency. Each quality management function has its own guidelines, designated implementation staff, and process of identification, communication, and remediation. This allows for timely evaluation of information and development of an appropriate action plan for the individual issue(s) identified. Systems improvement efforts are based upon the consolidation and analysis of data from all functions, as well as other information.

The following are the identified quality functions performed by the DD.

- ***service monitoring: the process in which service coordinators review appropriate service provision, consumer well-being and, for participants in residential services, environment and safety, findings requiring action of this process are entered into the Action Planning Tracking System (APTS) database;***
- ***incident response: reporting, tracking and trending of identified incident/injury/med error/restraint data, all information data based in the statewide Event Management Tracking System (EMT);***
- ***mortality review: the organized method of reporting and review of the circumstances of a consumer death while receiving funded services, requires local (regional office) review as well as a central office review, now completed in a web-based database;***
- ***health identification and planning system (HIPS) and nurse review: the process in which service coordinators document potential health needs for consumers in residential services; when needs meet an identified threshold, an in-depth review by a QE RN is conducted and recommendations made for planning, risk mitigation and provider supports***
- ***fiscal review for purchase of service system or medicaid waiver programs or services: designated fiscal staff;***
- ***service plan review: regional office staff review samples of plans for all waivers, samples are drawn by state-level QE staff with sample sizes using RAO-Soft, and findings requiring action of review are entered into APTS;***
- ***the licensure and certification (L&C) process: certification survey process for providers of residential, day services and employment services, conducted every other year, findings requiring action entered into APTS data base.***
- ***provider relations review: a review of provider business activities and contractual conformance done by regional provider relations staff at designated intervals and based upon trending of other quality function data reported to provider relations;***

- ***quality enhancement review: regional office quality enhancement staff conduct one-one interviews and observations with participants. The Sample size is the same as required for the National Core Indicators participation. Findings requiring action are entered into APTS;***

~~**The following are the identified quality functions performed by the DD.**~~
~~**• service monitoring: the process in which service coordinators review appropriate service provision, consumer well-being and, for participants in residential services, environment and safety, results of this process are entered into the Action Planning Tracking System (APTS) database;**~~
~~**• incident response: reporting, tracking and trending of identified incident/injury/medication error/restraint data, all information data based in the statewide Event Management Tracking System (EMT);**~~
~~**• mortality review: the organized method of reporting and review of the circumstances of a consumer death while receiving funded services, requires local (regional office) review as well as a central office review, completed in a web-based database;**~~
~~**• health identification and planning system (HIPS) and nurse review: the process in which service coordinators document potential health needs for consumers in residential services; when needs meet an identified threshold, an in-depth review by a Quality Enhancement RN is conducted and recommendations made for planning, risk mitigation and provider supports**~~
~~**• fiscal review: designated fiscal staff review claims of providers;**~~
~~**• service plan review: supervisors review samples of service plans for all waivers and also includes information regarding level of care, samples are drawn by Quality Enhancement Leadership team staff with sample sizes using RAO Soft, web-based tool used for review and results of review are entered into APTS;**~~
~~**• the licensure and certification (L&C) process: certification survey process for providers of day habilitation and supported employment, conducted every other year, results entered into a database specific to L&C;**~~
~~**• provider relations review: a review of provider business activities and contractual conformance done by regional provider relations staff at designated intervals and based upon trending of other quality function data reported to provider relations;**~~
~~**• quality enhancement review: a review of providers conducted by regional QE staff at designated intervals assessing provider systems for assuring health and safety of consumers, results tracked in APTS; and**~~
~~**• tracking of provider accreditation status: accredited providers are deemed to be certified and regional and state staff assure that requirements for submitting accreditation reports and communication with accrediting bodies are met, status of accreditation is entered into CIMOR.**~~Data for trending, prioritizing, remediating and implementing system improvements is continually collected through the identified quality functions, entered into databases, and analyzed/reported at designated intervals. Reports are provided to Division management, regional level management and staff, providers, stakeholders, and the Medicaid agency at designated intervals, dependent upon the specified function and need. The state-wide Quality Enhancement (QE) Leadership Team provides the oversight, management and evaluation of the quality improvement processes/strategy for the Division of DD.

The Division reports quarterly to the Mental Health Commission on performance measures that the Commission identified; these performance measures ~~**overlap**~~***incorporate data used from a selection*** ~~**those used for**~~ ***of the*** waiver assurances and ***also*** include***s information regarding*** abuse/neglect investigations, ~~**medication usage and**~~ medication errors, deaths, consumer injuries ***and*** use of restraints. ~~**and other indicators.**~~

The Mental Health Commission consists of community ~~**representatives for**~~ ***representatives in the field***

of ~~**psychiatric, addiction**~~ ***behavioral health*** and ***intellectual and*** developmental disabilities appointed by the governor. This public forum is attended by providers***, and*** self-advocates and family members.

Reports are also shared with the Quality Advisory Council, a group of self-advocates and family members or guardians. The Quality Advisory Council represents a cross-section of advocacy groups, family members, consumers and public guardians. The Council reviews a wide variety of information from waiver performance, National Core Indicators (NCI), all quality ***integrated*** functions, current grants and Division initiatives.~~**, such as progress on Money Follows the Person, College of Direct Support, employment and consumer self-direction of services.**~~

In addition to the quality functions used by the state, DD participates in the NCI initiative. With ***40***~~**31**~~ other states participating in this initiative, DD can compare results with a national average as well as the other participating states, using the information as benchmarks.

~~**The QIS plan/processes span all DD waivers, and non-Medicaid services as well. DMH process would not extend to State Plan or to other state departments' waivers. Data collection, analysis, and reporting for the waiver assurances are separated out by each of the DD waivers: DD Comprehensive Waiver(MO.0178), DD Community Support Waiver (MO.0404), Missouri Children with Developmental Disabilities Waiver (MOCDD) (MO.40185), Autism Waiver (MO.0698) and Prevention Waiver (MO.0814**~~). The process for trending is grounded in the CMS waiver quality assurances. Data is aggregated and reported state-wide, by individual region, and, at the regional level, by provider and consumer. The state Quality Enhancement Leadership Team tracks and evaluates remediation at the regional or state level for identified trends.

Process for Trending

The state QE Leadership team analyzes and reports information to senior Division management and regional directors from service monitoring, service reviews, level of care, incident/injury, and abuse/neglect quarterly. These reports include summarizing performance in the identified areas, describing any patterns/trends, and discussing actions needed. These reports aggregate data state-wide and also aggregate by region. If trends are noted to occur within specific regions or with certain contracted providers, the Division of DD Statewide Quality Enhancement Team notifies Regional Office QE staff of the concerns to be addressed locally.

Regional QE staff review all integrated function databases for trends in service monitoring, incident/injury/abuse/neglect, remediation for service plan reviews, provider relations reviews, and QE reviews in their specific region to identify any significant patterns, trends, or concerns. These reports summarize regional trends for waiver and non-waiver services, specific provider issues and specific consumer issues. Each region develops reports on identified trends to be addressed locally with community providers and the Regional Offices.

Performance measures as outlined in each of the waiver quality assurances are analyzed and reported by state QE staff to the state Medicaid agency (MO HealthNet) quarterly. In addition to the written reports, the DD Federal Programs Unit, DD QE staff and MO HealthNet meet quarterly to review the data reports/trends specific to each waiver and discuss other issues pertinent to the performance measures and the operation of the waivers.

The QE Leadership Team generates an annual report which includes aggregate information from all the quality functions, comparing data year to year, identifying improvements and opportunities for improvement.

Implementation of system improvements

When patterns or trends are identified from the data and the reviews mentioned above, further analysis is conducted by the Quality Enhancement Leadership Team along with stakeholders who are involved in the identified trends. Work groups may then be developed to determine what systems improvement strategies could be developed to impact the areas identified. Sometimes this process results in policy/procedure changes, technical assistance with providers or private TCM entities, training with state staff, or it could be in the form of an awareness campaign to bring a more heightened attention to the identified situation.

Changes in rules, policy, and contracts are drafted and distributed to allow feedback from stakeholders. Once finalized, changes are distributed to Division DD's staff and contracted providers. Discussions are held at local provider meetings, as well as statewide coalitions of providers to assure that changes are understood and implementation dates are communicated. Any training required to assist with the implementation of these changes are initially planned and coordinated by state Quality Enhancement Leadership Team and then assumed by regional office staff. The implementation of system improvements is analyzed for effectiveness of remediation through periodic reviews, and through ongoing analysis of related data

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of monitoring and analysis** *(check each that applies):*
X State Medicaid Agency	☐ **Weekly**
X Operating Agency	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	**X 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.

Following implementation of revisions to rules, policy, practices, contracts, or training techniques, data is continually reviewed and analyzed as discussed above in system improvements, to assess effectiveness and appropriateness of the changes. The Quality Enhancement Leadership Team provides feedback and recommendations for system design changes to administration based on identification of trends.

Examples of system improvements:

Regular reviews of the abuse/neglect reporting data resulted in examination of the training components for this topic. Workgroups analyzed the abuse & neglect online training scores as well as comments from those who took the courses which then lead to changes which included examples that better described situations of abuse, neglect, and misuse of consumer funds. The training was revised and tests were re-designed. There has been a decline in abuse and neglect substantiations;

The process for development and revisions of Division Directives (policy and procedural requirements) has been altered to include public comments, identified trends and changes in programs. If a directive affects a broader base than just an internal work process, work groups are identified with representatives from the Division, Regions, providers and/or consumers of services for input. A draft of the Directive is posted on the Division's public web site for a comment period prior to finalizing and issuing the Directive. Anyone accessing the web site can register to have an automatic e-mail notification when changes to the site are made, documents posted and so forth.

A minimum set of incident data sets have been identified to assist in consistency of reporting and allows for comparisons state-wide and across regions.

A web-based survey has been designed that is filled out by all Regional QE staff upon completion of Quality Enhancement reviews related to Health and Safety to help evaluate the review process. This was successful in evaluating the survey process and the Provider Relations staff also implemented this for the Provider Relations Review. In addition, a web-based survey was established to allow providers to evaluate any contact/visit from regional staff.

Statewide training was implemented for service coordinators on how to use data to help identify areas of potential risk for consumers so that risk planning for the consumer would be addressed.

The Action Plan Tracking System (APTS) had two additional fields added: 1) Resolution Date- This allows us to identify issues that are unresolved for follow-up. 2) Remediation and comments were added to each record so we can determine what measures are being taken to prevent the issue from occurring in the future.

We are currently in the process of redesigning the incident data collections system (EMT) department-wide. This was a result of data integrity reviews and data analysis. Changes to the system will ensure more consistency with data entry, a more user-friendly data entry, as well as providing additional information related to incident types. Input for changes to the system came from a variety of stakeholders including data entry staff, quality enhancement staff, providers, DD QA Advisory Council, habilitation center staff, and information technology staff.

The Division has tracked Medication Aide training and periodic updates for many years. The old data base was difficult to use, manage and was region-based, so did not "communicate" state-wide and thus was difficult to use for checking credentials. In fall 2010, a new web-based design was implemented that is much more user-friendly for data entry and also is available state-wide to check credentials. So, if a medication aide would move from the Joplin area, for instance, to St. Louis and began working for a provider, someone in St. Louis could check the data base to verify current Medication Aide certification.

The Health Inventory process relied on completing paper forms and reports from the process were done manually. In January 2010, the inventory was incorporated into the Department's main database (CIMOR) which now captures the information electronically and allows us to generate reports more easily and track the health information about consumers.

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

There are several points at which the quality improvement strategy is evaluated. As data is reported at the identified intervals, data integrity and fidelity of the review processes are also evaluated. This allows an opportunity to impact design of the quality strategy, discovery processes, remediation effectiveness and methods, and prioritizing for systems improvement.

Each quarter at both the regional and state level, the results of the discovery processes are reported. This is also an opportunity to note changes, trends, and to identify if those trends indicate a need for updating the quality improvement strategy.

The results of the QI strategy is also combined with information from a variety of activities and stakeholder input that occurs within the Division and the Department of Mental Health. For example, the Department participated in a personal planning grant which spanned both the Division of DD and Division of Comprehensive Services. The DD data related to the service planning assurances, gathered by the service plan review process, in addition to stakeholder meetings for the grant identified an opportunity to improve the planning process. Changes to the person-centered planning guidelines were achieved and also supported a risk assessment and mitigation component. This then circled back into revising some of the information asked in the discovery process for the service planning assurance – service plan review.

The state Quality Enhancement Leadership Team reviews trends every quarter and is responsible for identifying patterns or trends that would indicate need for changing of the strategy and/or activities supporting the implementation of the quality improvement strategy. Another example to illustrate this is the use of the EMT and classifying incidents accurately. Through the quarterly reporting process, the overuse of the category of “other” for incident type was identified. Since this system is an integral component of the quality improvement strategy, accurate data is crucial for identifying needed action. A two year project of intense review of how incidents were classified and technical assistance with regional QE staff and data entry personnel resulted in reducing the use of the category of “other” by 83%, and this category now is used for only about 2% of all reported incidents/injuries.

Another example of impacting the quality improvement strategy is the regional office review of level of care, where they are now able to pull reports at the regional level to internally monitor and correct inaccuracies in data entry errors. The remediation is completed prior to the quarterly data extraction. This is a more proactive strategy rather than reactive.

On an annual basis, the quality improvement strategy is evaluated and summarized in the annual report. When changes are needed, objectives are outlined and strategies to meet those objectives are identified and assigned. The information is presented to Division of DD management.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

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

a) Requirements concerning the independent audit of provider agencies:

Contract providers that provide services to individuals who participate in 1915(c) waivers administered by the Division of Developmental Disabilities are not considered sub-recipients as defined in United States Office of Management and Budget (OMB) Circular A-133 Section 210(b) since they do not have responsibility for determining program and service eligibility and they do not make programmatic decisions.

Division of Developmental Disabilities contract providers that expend $500,000 or more in federal grant funds received from the Department are required by the Department of Mental Health (DMH) contract to have an annual audit conducted in accordance with United States Office of Management and Budget (OMB) Circular A-133. The reporting package specified in OMB A-133 must be filed with the DMH. Division of Developmental Disabilities (Division of DD) rate setting staff receives and reviews this information. All other providers are encouraged to voluntarily submit independent audit reports to the Division of Developmental Disabilities rate setting staff for review for any deficiencies and are maintained for future reference. All providers are required to submit an annual Uniform Cost Report to the Division. The reports are maintained and referenced when rate adjustments are requested.

Expenditures for this waiver are subject to the State of Missouri Single Audit conducted by the Missouri State Auditor's Office. Audits may be conducted by the Audit Services Unit of the Department of Mental Health upon request. Audits may be requested by the Director of the Department of Mental Health or the Director of the Division of Developmental Disabilities based upon monitoring results, recommendations from Regional Offices, reports from provider staff, reports from the general public, etc.

b) As per the memorandum of understanding (MOU) between the Department of Mental Health (DMH)and the Department of Social Services (DSS) effective September 2011 there is a Medicaid Audit and Compliance Unit (MMAC) within DSS which directly manages and administers Medicaid program integrity, audit and compliance, and Medicaid provider contracts. The Division of DD is the division within DMH responsible for provision of services to individuals with developmental disabilities. Division of DD provides Targeted Case Management and waiver services as part of their service delivery. MMAC and Division of DD work in conjunction with regard to assuring program integrity, audit and compliance for Medicaid services. More specifically MMAC conducts provider reviews to ensure provider qualifications and services rendered in accordance and compliance with the Medicaid Program, the service plan, waiver services program, and all applicable federal and state laws

and regulations. MMAC will also conduct internal audits of Division of DD enrolled Medicaid waiver providers to ensure payments comply with home and community based waiver assurances.

c) Agency (or agencies) responsible for conducting the financial audit program:

1. MO HealthNet and MMAC reviews a sample of waiver provider billings annually and conducts compliance audits, at least every two years, in which documentation of services provided is reviewed to ensure services billed to MHD were provided and documented as required (13 CSR 70.3); the MMIS includes edits to ensure appropriate payments.

2. Department of Mental Health, Office of Audit Services, conducts financial audits upon referral from Division of DD Administrative staff or Regional Office staff, based on information from routine fiscal reviews, complaints from stakeholders or misuse of funds allegations. This entity does not conduct routine financial reviews.

3. State Auditor's Office conducts financial audits under the Single State Auditor based on information from stakeholders.

As part of the Medicaid provider enrollment process, all waivered service providers are required to have a Department of Mental Health Purchase of Service contract. The Department of Mental Health serves as the billing agent on behalf of all waiver service providers since the Department maintains the prior authorization system. This process pertains to all waiver services which are all prior authorized.

The Division of DD's automated network allows case managers to request services identified in the individual's service plan. Before services are authorized, all new plans and plans requesting increased services must go through the Regional Office's Utilization Review process for approval. Approved services are input in the prior authorization system.

The automated prior authorization system creates an invoice for the provider from authorized/approved services. Using a personal computer and modem, the provider can access the invoice electronically and bill for authorized services that have been delivered. Division of DD regional office staff print and review an edit report of services providers have input as delivered to determine if any adjustments are necessary. After determining services input appear accurate, the claim data is submitted to the Medicaid Agency's fiscal agent for processing.

For residential habilitation services, the provider submits an invoice to the Division of DD regional office via modem, showing the dates each individual was present and absent. The system divides the allowable reimbursement amount for the month of service by the number of days the individual was present, to calculate an adjusted per diem. This per diem is billed to Medicaid only for those dates when the individual was present. The Medicaid fiscal agent pays the lesser of the provider's billed charged or the maximum allowable rate established in the MMIS.

Claims are submitted electronically to the MO HealthNet fiscal agent and are subjected to appropriate edits in the MMIS system to ensure that payment is made only on behalf of those clients who are Medicaid eligible, and to providers who are enrolled, on the date a service was delivered. The provider subsequently receives payment directly from the Medicaid Agency as reimbursement for services rendered. A remittance advice indicating the disposition of billed services accompanies the provider's reimbursement.

The audit trail consists of documents located in the Department of Mental Health, Division of DD regional offices, MO HealthNet Division, and with the provider of service. The Division of DD regional offices maintain the individual service plan. Corresponding plans of care are maintained in the

automated systems at regional offices, along with invoices for authorized services. The Division of DD also maintains billed claim data for all claims submitted to MO HealthNet, Medicaid remittance advices, and a history of authorized and paid services by fiscal year. The information collected and maintained by the Medicaid agency's MMIS system includes: copies of all paid and denied claims; Medicaid remittance advices; and eligibility information on each individual served.

Providers are required to maintain financial records and service documentation on each person served in the waiver including the name of the recipient, the recipient's Medicaid identification number, the name of the individual provider who delivered the service, the date that the service was rendered, the units of service provided, the place of service, attendance and census data collection, progress notes and monthly summaries.

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. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-assurances:

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

a.i. Performance Measures

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

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

Performance Measure:	***Number and percent of paid claims properly coded for the given waiver (Number of paid claims properly coded for the given waiver divided by Number of paid claims for the given waiver)*** ~~**Number and percent of claims paid for services included in the approved service plan. (Total claims for delivered services that identified in the service plan ÷ by the total number claims reviewed)**~~

Data Source *(Select one) (Several options are listed in the on-line application):* ***Financial Records (including expenditures)***~~***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*	*X 100% Review*
	X Operating Agency	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

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*
X Operating Agency	☐ *Monthly*
☐ *Sub-State Entity*	*X Quarterly*
☐ *Other*	*X Annually*

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

Performance Measure:	***Number and percent of paid claims for individuals enrolled in the waiver as of the date of service (Number of paid claims for individuals enrolled in the waiver as of the date of service divided by Number of paid claims for the given waiver) ~~Number and percent of claims paid for waiver services that adhere to the reimbursement methodology of that waiver (total claims paid for services in the waiver that adhere to reimbursement methodology divided by the total number of claims reviewed).~~***

Data Source *(Select one) (Several options are listed in the on-line application):* ***~~Record Reviews on-site~~***

If 'Other' is selected, specify: ***Medicaid paid claims; CIMOR screens that indicate dates individuals are actively enrolled in the waiver.***

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

applies	*applies*
X State Medicaid Agency	*☐ Weekly*
X Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*X Quarterly*
☐ Other Specify:	*X Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

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

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

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

Performance Measure:	***Number and percent of initial and amended waiver contracts implemented with the rate methodology described in the waiver (Number of initial and amended waiver contracts implemented with the rate methodology described in the waiver divided by Number of initial amended waiver contracts implemented)***		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify: ***Share Point, DD reporting, Data Central, Report Manager.***			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*√ 100% Review*
	√ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*√ Quarterly*	*☐ Representative Sample; Confidence*

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

Add another Data Source for this performance measure

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:*

Add another Performance measure (button to prompt another performance measure)

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

1. All waiver services are prior authorized. All approved waiver services for waiver-enrolled persons are input into the prior authorization system in CIMOR. DMH serves as the billing agent on behalf of all waiver service providers since DMH maintains the prior authorization system. The automated prior authorization system creates an invoice for the provider from authorized/approved services. The provider can securely access the invoice to enter the approved services delivered. Claims are submitted electronically to MO HealthNet fiscal agent and subject to the appropriate edits in MMIS to include persons were Medicaid eligible and providers were actively enrolled with MO HealthNet on date of service.
2. Prior authorized services include the rate that is authorized. Only the amount authorized can be paid.
3. Payment is not made through the MMIS unless a valid waiver procedure code has been authorized and billed.

~~**1. All waiver services are prior authorized. Payment is not made through the MMIS unless a valid waiver procedure code has been authorized and billed.**~~
~~**2. Prior authorized services include the rate that is authorized. Only the amount authorized can be paid.**~~

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. In addition, provide information on the methods used by the State to document these items.*

1) For performance measure I.i.a.i.1, any claims billed to MO HealthNet that are not covered waiver services will be adjusted so that reimbursement is returned to MO HealthNet.
2) Performance measure I.i.a.i.2 involved tracking on a quarterly basis to ensure paid claims for an individual service recipient are applied to the waiver with which he or she is enrolled on each date of service. This is verified by comparing the date of service and eligible dates for the individual in receipt of the waiver. Any service claims paid for the individual outside of the eligibility dates will be returned to MO HealthNet
~~**Review findings of any discrepancies will be reported in writing within ten (10) days to the Regional Office staff, who will coordinate the remediation including:**~~
~~**1) verifying the service provided was or was not authorized in the plan of care. If confirmed the service provided was not in the plan of care, an adjustment will be submitted to MO HealthNet. The service coordinator supervisor will discuss the finding with the service coordinator and assure the service plan is accurately updated and provide additional training. Designated Regional Office staff will notify the audit authority of remediation in writing within thirty (30) days specifying remediation that occurred to correct each individual problem identified.**~~
~~**2) Any claims billed to MO HealthNet that are not covered waiver services will be adjusted so that reimbursement is returned to MO HealthNet.**~~
~~**3) Any claims billed to MO HealthNet with a rate that is not consistent with the rate setting methodology are adjusted (reimbursed) to MO HealthNet and a new rate according to methodology will be determined and billed.**~~

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**
	X Operating Agency	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other**	☐ **Annually**

	Specify:	
		X 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.

X	**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-2: Rates, Billing and Claims

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

Each Division of DD Regional Office has Provider Relations staff assigned to work with Division of DD Waiver Providers. ~~**Staff explains the program and qualifications required to provide services. Interested providers are given a budget packet to complete. The forms in the packet allow the potential provider to report its cost to provide a specific waiver service. The reported costs are reviewed by staffand a unit rate is negotiated. Each provider's rate is set based on reported costs with the condition the rate must not exceed the maximum allowable set by the state for that particular service code. The cost analysis requires approval from the Regional Director as well as Central Office, if the provider is requesting a rate higher than the average reimbursed to other providers of the same service in that region. If the provider accepts the average rate, no cost analysis is required. A maximum allowable for each service is calculated and is applied across all areas of the State. If a maximum allowable is not sufficient in one part of the state, it is adjusted for the entire state. This process is used for all waiver provider/agency based services except the behavior analysis service (specifically the functional behavioral assessment), out of home respite, environmental accessiblity adaptations, specialized medical equipment and supplies, community.**~~

~~**For residential habilitation services (group home settings), the rate setting process is described in CSR 45-4.010, Residential Rate Setting. The SIS is licensed by the American Association on Intellectual and Developmental Disabilities, and directly measures the level of supports needed to enable an individual to participate successfully in the life of his or her community. The SIS may only be done by professionals who have successfully completed the AAIDD Training. The interview will be with the individual and include information from people who have first- hand knowledge of the individual. Developed to measure the construct of supports, the SIS has greater face validity than other traditional assessments.**~~

~~**Providers fill out a budget packet to demonstrate cost for providing the service. The provider can accept a profile rate based on the level of care that will be provided, or a committee of Division staff and the provider will meet to negotiate the rate. Parameters considered in negotiating the rate include:**~~

- ~~**staffing ratios required based on the level of care needs of prospective persons to be served;**~~
- ~~**extraordinary circumstances beyond the control of the facility such as location; and**~~
- ~~**costs the provider reports for direct care staff, professional staff, administrative services, fringe benefits, ancillary costs, etc. in comparison with known costs of other providers in the region that provide similar services.**~~

~~**Individualized supported living rates are individually set. A budget is developed for each waiver participant who receives individualized supported living (residential) services. The provider develops a budget based on the individual's needs as described in the individual service plan. The regional office reviews the proposed budget, makes adjustments if needed, and approves the final budget which is developed to a rate.**~~

~~Rates for residential services do not include room and board charges. The provider has separate contract rates for Room and Board costs and residential habilitation. Room and Board and residential habilitation is based on a daily rate. Providers are reimbursed for room and board costs through a separate payment process. Room and Board is billed through separate procedure codes on a separate invoice from that of waiver residential habilitation. Room and Board is paid directly to the provider by Department of Mental Health using State only funds. No FFP is used for room and board.~~

~~Host home rates are based on level of supervisory oversight needed with a supplementary payment based on the individual's score from the Support Intensity Scale, (SIS), The SIS is licensed by the American Association on Intellectual and Developmental Disabilities, and directly measures the level of supports needed to enable an individual to participate successfully in the life of his or her community. The SIS may only be done by professionals who have successfully completed the AAIDD Training . The interview will be with the individual and include information from people who have first- hand knowledge of the individual. Developed to measure the construct of supports, the SIS has greater face validity than other traditional assessments.~~
~~Host home rates are based on level of supervisory oversight needed. Room and board costs are excluded from the host home rates.~~

~~Level 1: Less than 24 Hour Supervision~~
~~Assist and instruct individuals who require support to maintain a living arrangement. The individual may require support in learning only particular life skills or parts of skills. The individual can evacuate the home independently in an emergency and may have unsupervised time in the home and/or community as indicated in their ISP.~~

~~Basic SIS supplement includes provider responsibility for supports as reflected in the person's Individual Support Plan and the level of support as indicated in the Support Intensity Scale assessment.~~

~~Level 2: 24 Hour Supervision~~
~~Assist, instruct, and supervise individuals who require support in learning a variety of daily living skills and require 24 hour supervision to ensure their safety.~~

~~Basic SIS supplement includes provider responsibility for supports as reflected in the person's Individual Support Plan and the level of support as indicated in the Support Intensity Scale assessment.~~

~~Level 3: 24 Hour Comprehensive Support~~
~~Assist, instruct, and supervise individuals who, because of severe, multiple and chronic disabilities, require intensive supervision and/or a specially adapted environment and/or a combination of professional support services for the foreseeable future as indicated in the person's Individual Support Plan. Individuals who require on- going comprehensive support have needs in one or more of the following areas:~~

~~Medical~~
~~Uncontrolled frequent seizures~~
~~Specialized medical and feeding methods (G-tube, Trachs, Choking precautions)~~
~~Long term physician prescribed interventions such as MD visits, psychiatric visits etc.~~

~~Behavioral~~
~~Chronic mental health issues~~
~~Destructive and/or self injurious behaviors~~
~~Physical aggression~~
~~Elopement~~

~~Self Care~~
~~Full assistance needed for one or more of the following: toileting, eating, dressing, hygiene/grooming, bathing.~~

~~Basic SIS supplement includes provider responsibility for supports as reflected in the person's Individual Support Plan and the level of support as indicated in the Support Intensity Scale assessment.~~

~~The SIS score will be used to determine a supplemental payment for the level of support needed in addition to the base level supervisory support rate for Levels 1, 2, and 3. The SIS scoring would be categorized into five (5) levels based on the SIS score:~~

~~Level~~	~~Index~~	~~SIS Score~~	~~SIS Supplement/day~~
~~Level I~~	~~68-90~~	~~0~~	~~0~~
~~Level II~~	~~91-101~~	~~1-2~~	~~5~~
~~Level III~~	~~102-113~~	~~3-4~~	~~10~~
~~Level IV~~	~~114-123~~	~~5-6~~	~~15~~
~~Level V~~	~~124-134~~	~~7~~	~~20~~

~~For Behavior Analysis Service (specifically the functional behavioral assessments), a flat fee is paid. The fee was established based on the average time expected to be required for a professional to complete an assessment.~~

~~For environmental accessibility adaptations, specialized medical equipment and supplies a flat rate is not used. Bids or estimates of cost for a job, equipment, or supplies are obtained from two or more providers the individual chooses. A dollar amount is authorized for the provider with the lowest and best price if the price is reasonable based on the purchase experience of the regional office of similar jobs, equipment or supplies and does not exceed the annual maximum allowed for the service.~~

~~Division of DD uses a prospective cost based method to establish rates for all services other than out of home respite and the behavior analysis service (specifically the funtional behavioral assessment). The rate cannot exceed the maximum allowable rate set by the state for each service. The maximum rate for each service is entered in the MMIS procedure code file which all waiver claims process against. MO HealthNet must approve any changes to the maximum allowable in the MMIS proposed by the Division of DD. MO HealthNet considers the rates paid for similiar MO HealthNet services, access to service providers with current rates, and whether there is sufficient State appropriation to cover the State share.~~
~~Individuals, providers, and other stakeholders have an opportunity to make public comments to the Division of DD, MO HealthNet, and elected officials on rates and methodology for rate setting during annual legislative hearings in preparation for the appropriation process. Providers and other stakeholders may provide comment to the Division of DD Director or Department of Mental Health Director at any time regarding rates by writing a letter or during public meetings.~~

~~During the person centered planning process when service providers are selected, the~~

~~**participant is informed of provider rates. Also, participants are given a copy of their approved budget which contains the rate for each service they are approved to receive.**~~

~~**If an individual requests a new provider that has a higher rate, a new budget is prepared for the individual. The new budget is sent to the UR Committee. If additional units are not requested, but the budget has increased due to the new provider's rate, the budget is usually approved unless the new rate will cause a program or service limitation to be exceeded in which case the UR Committee may recommend fewer units of service.**~~

~~**All maximum allowable rates are approved by MO HealthNet.**~~

The rate methodology for each group of services is described below. All services may be adjusted for inflation, cost and/or utilization. A maximum allowable for each service is calculated and is applied across all areas of the State. If a maximum allowable is not sufficient in one part of the state, it is adjusted for the entire state.

Residential Habilitation Services: Group home settings, Individualized Supported Living and Shared Living models are based on level of supports needed based on the individual's Rate Allocation Score derived from the Support Intensity Scale, (SIS)licensed by the American Association on Intellectual and Developmental Disabilities, or other state approved assessment tool; herein referred to an "assessment" as it relates to residential rates.
Rates for residential services do not include room and board charges. The provider has a separate contract daily rate for Room and Board costs Room and Board is paid directly to the provider by Department of Mental Health using State only funds or is collected directly from the consumer/conservator by the provider. No FFP is used for room and board.

Group Home Residential Habilitation rates are based on the individual's rate allocation score. Target group home rates have been established by the state for each rate allocation score for small and large group home settings. Rates for new participants are individualized and not based on the group home's historical rates. If a participant does not yet have a rate allocation score, they are budgeted at the lowest score until an assessment can be completed.

Individualized Supported Living daily rates are based on a budget that is developed for each waiver participant which utilizes a staffing pattern and an hourly rate determined by the individual's rate allocation score. Hourly direct care rates for each rate allocation score have been established by the state. If a participant does not yet have a rate allocation score, they are budgeted at the lowest score until an assessment can be completed. The provider develops this budget based on the individual's needs as described in the individual service plan. The regional office reviews the proposed budget, makes adjustments if needed, and approves the final budget which is developed to a daily rate.

Shared Living rates are based on the level of supervisory oversight needed plus a supplementary payment based on the individual's score from the Support Intensity Scale, (SIS), or other state approved assessment tool. Room and board costs are excluded from the host home rates.
Shared Living rates are based on three levels:
Level 1: Less than 24 Hour Supervision
Level 2: 24 Hour Supervision
Level 3: 24 Hour Comprehensive Support

A Basic Assessment supplement (Level 1 – 5) is added to the rate based on supports as reflected in the person's Individual Support Plan and the level of support as indicated in the assessment.

Day Services: *This includes Community Integration, Day Habilitation, Individual Skills Development and agency-based Personal Assistance. Division provider relations staff work with interested providers on completing a budget packet. The forms in the packet allow the potential provider to report its cost to provide a specific waiver service. The reported costs are reviewed by staff. Each provider's rate is set based on reported costs with the condition the rate must not exceed the maximum allowable set by the state for that particular service code.*

Personal Assistance - Self Directed: *This includes individual personal assistance, medical/behavioral personal assistance, team conference and self-directed support broker. Employers (families, individuals, guardians) are given a budget that is based on the determined hours needed of the individual at the average agency personal assistance rate by region of the state. The employer sets the actual rate of the direct care staff based on local wages and other factors so long as they stay within their budget. The per-unit cost cannot exceed the maximum allowable set by the state.*

Respite Care In Home *rates are set by Division provider relations staff who work with interested providers on completing a budget packet. The forms in the packet allow the potential provider to report its cost to provide a specific respite service. The reported costs are reviewed by staff. Each provider's rate is set based on reported costs with the condition the rate must not exceed the maximum allowable set by the state for that particular service code.*

Day Habilitation Medical/Behavioral *is paid a flat rate to all providers statewide. The methodology to establish this rate is as follows: The hourly rate is calculated by using the US median salary for an LPN adjusted slightly for Missouri. Fringe of approximately 29% is added to the base salary to cover health exchange Gold plan, 7.65% FICA, 10 leave days, and CNA certification expenses. Agency overhead equal to 15% of base salary is added to the total salary to cover the physical plant and administration. The total compensation package is divided by 2,080 hours to develop the hourly cost of the CNA/LPN. An additional per hour cost for RN oversight is added to the CNA/LPN rate and the new total is divided by the annual average per person units of day habilitation based on actual utilization. The hourly rate is divided into four 15 minute increments for billing purposes.*

Transportation *rates are set based on cost-based bids submitted by providers who for specific routes and regions. Provider Relations staff use these costs to establish a rate per unit. Theunit may be computed as per mile, per trip or some other unit but are billed as a monthly total based on actual utilization so long as the total monthly amount does not exceed the maximum allowable set by the state.*

Behavior Services: *Includes Behavior Identification Assessment, Observational Behavioral Follow-Up Assessment, Exposure Behavioral Assessment, Exposure Behavior Follow-Up Assessment, Adaptive Behavior Treatment with Protocol Modification, Exposure Adaptive Behavior Treatment with Protocol Modification, Adaptive Behavior Treatment by Protocol by Technician, Family Behavior Treatment Guidance, and Behavior Treatment Social Skills.*

The unit rate for services provided by a licensed behavior analyst (LBA), a psychologist, or other Qualified Health Care Professional was calculated at an amount for 30 minutes of service.

This calculation is based on a combined highest range of salary of Licensed Behavior Analysts per MO Office of Administration Merit Classification) and the highest range of salary for Psychologists II MO Office of Administration Merit Classification), adding an administrative fee rate used by the University of MO for fringe benefits, calculated 50 billable hours for psychologists and 44% billable hours for Licensed Behavior Analysts (6% difference from

psychologist's billable hours attributed to travel) using a full time equivalent work year of 2080 hours.
The unit rate for services provided by a licensed assistant behavior analyst or a registered behavior technician was calculated at an amount for 30 minutes of service.
This calculation is commensurate with a rate set for behavioral personal assistance (discontinued with this waiver renewal). The education and experience required for behavioral personal assistance is similar to that required for the registered behavior technician.

Supported Employment reimbursement rates are set at the Medicaid Waiver cap. The rate was established based on the costs associated with increased staff training.

Prevocational Services and Career Planning reimbursement rates are set at Medicaid Waiver cap for the service or for cap rate for Supported Employment, whichever is lower. These rates were established based on the costs associated with increased staff training.

Professional Services such as Professional Assessment and Monitoring, Physical Therapy, Occupational Therapy, Speech Therapy, Support Broker, Community Specialist, and Communication Skills Specialist reimbursement rates are set at the Medicaid Waiver cap. These rates were established based on the expertise required of the professional/semi-professional.

Crisis Intervention rates are set by Division provider relations who work with interested providers on completing a budget packet. The forms in the packet allow the potential provider to report its cost to provide the service. The reported costs are reviewed by staff. Each provider's rate is set based on reported costs with the condition the rate must not exceed the maximum allowable set by the state for that particular service code.

Community Transition is the actual cost of one-time services that meet the service definition presented by the provider of residential services and approved by the regional office.

Special Equipment, Supplies and Services: For environmental accessibility adaptations, specialized medical equipment and supplies and Assistive Technology a flat rate is not used. Bids or estimates of cost for a job, equipment, or supplies are obtained from two or more providers the individual chooses. A dollar amount is authorized for the provider with the lowest and best price if the price is reasonable based on the purchase experience of the regional office of similar jobs, equipment or supplies and does not exceed the annual maximum allowed for the service.

Individuals, providers, and other stakeholders have an opportunity to make public comments to the Division of DD, MO Healthnet, and elected officials on rates and methodology for rate setting during annual legislative hearings in preparation for the appropriation process. Providers and other stakeholders may provide comment to the Division of DD Director or Department of Mental Health Director at any time regarding rates by writing a letter or during public meetings.

During the person centered planning process when service providers are selected, the participant is informed of provider rates. Also, participants are given a copy of their approved budget which contains the rate for each service they are approved to receive.

If an individual requests a provider that has a higher rate, a new budget is prepared for the individual. The new budget is sent to the UR Committee. If additional units are not requested, but the budget has increased due to the new provider's rate, the budget is usually approved unless the new rate will cause a program or service limitation to be exceeded in which case the

UR Committee may recommend fewer units of service.

All maximum allowable rates are approved by MO Healthnet.

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

The Division of DD's automated consumer information system allows staff to request prior authorization of services identified in the service plan. Before services are prior authorized by the Regional Office, the service plan must go through the regional office's utilization review process if the plan is new or requests an increase in service.

Since the prior authorization system resides in the Department of Mental Health's information system, waiver providers are required to submit claims for services they provide through the operating agency's billing system and may not bill claims directly to MO HealthNet fiscal agent.

The operating agency's automated system creates an invoice for the provider from authorized/approved services. Using a personal computer and internet connection, the provider can access the invoice electronically and bill for authorized services that have been delivered. Division of DD Regional Office staff review edit reports of services providers have input as delivered to determine if any adjustments are necessary. After determining services input appear accurate, staff with the regional office submit the claims to the Department's billing system for transfer to MO HealthNet's fiscal agent.

The ASC X12N 837 Health Care Claim format is used for billing waiver services. Claims submitted electronically are subjected to appropriate edits in the MMIS system to ensure that payment is made only on behalf of participants who are MO HealthNet eligible, and to providers who are enrolled, on the date a service was delivered. The provider receives a remittance advice indicating the disposition of billed services and any reimbursement due, directly from MO HealthNet. The Division of DD also receives copies of remittance advices since the state share paid to providers is the Department's responsibility. The Division of DD is appropriated funds for the state share of waiver service programs it administers. As claims are adjudicated in the MMIS, Division of DD administratively transfers authority to MO HealthNet to access the state share portion of the payment made for waiver services from this appropriation.

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

X		**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.*)

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

(a) Waiver providers must submit bills through the Department of Mental Health where the Division of DD's prior authorization system resides. Claims must successfully process through the prior authorization system before the Department sends the claims to the MO HealthNet fiscal agent for processing through the MMIS claims processing system. There are edits within the MMIS to verify eligibility for each date of service before the system approves payment to the provider. If an individual is not eligible for any date of service, the MMIS claims processing system does not allow payment to the provider for periods of ineligibility.

(b)&(c) Billing validation to determine if services are provided is done once a year as part of MO HealthNet's review of a sample of waiver participants. Part of the process is to review the plan and ensure all service needs have been provided and that all services provided were included in the plan. Further, providers who received payment for services to participants selected for the review are contacted by the ~~**MO HealthNet's Program Integrity Unit**~~ ***Missouri Medicaid Audit and Compliance*** and must provide documentation that services were delivered. The Division of DD conducts a financial review of provider payments annually to ensure the provider has evidence/documentation that a sample of services were provided. Only authorized services are paid. Payment is made directly to the provider of services.

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-3: Payment

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

X	**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) 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:

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.**
X	**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.

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:*

X	**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.

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.*
X	**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. *Complete item I-3-e.*
	Some County Entities are reimbursed as waiver service providers, as well as Division of DD Regional Offices and habilitation centers. Out of Home Respite services may be provided as a direct service by a County Entity, or a habilitation center. County Entities and Regional Offices may also provide the following services as a direct service: residential habilitation, ISL, day habilitation, in-home respite, personal assistant, support broker, community professional, ~~**community employment**~~ ***supported employment, prevocational services,*** job discovery, ~~**job preparation, behavior therapy,**~~ crisis intervention, counseling, behavior analysis services, speech therapy, occupational therapy, physical therapy, professional assessment and monitoring, ~~**communication skills instruction**~~, environmental ***accessibility*** adaptations, specialized medical equipment and supplies, assistive technology, agency with choice fiscal management service, or transportation. The County Entity or Regional Office must have staff qualified to provide the service and must have been chosen by the participant to provide the service. Both County Entities and Regional Offices are more likely to provide waiver services under the OHCDS option, sub-contracting for waiver services from otherwise qualified providers

	that have chosen not to enroll as a MO HealthNet (Medicaid) ***billing*** provider.

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*:

X	**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:

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:*

X	**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.

g. Additional Payment Arrangements

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

X	**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.**
X	**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.** Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
	a) Entities that may be designated as an OHCDS are Division of DD Regional Offices and other MO HealthNet service providers that meet the requirements set forth in 42 CFR 447.10, and desire to serve as an OHCDS. There are no restrictions as to waiver services that may be provided under this option as long as all applicable provider standards are met for that service. State operated DD Regional Offices, County Boards, and designated not-for-profit entities provide Medicaid State Plan targeted case management. They have systems capable of contracting and paying other providers directly. Other waiver providers of MO HealthNet services may also elect to become an OHCDS provider if they are approved by the local Regional Office and have systems capable of contracting with and paying waiver service providers directly and meet the assurances. The ability to contract directly with providers allows consumers and families to select and develop or train individuals they want to deliver services and care, thereby increasing the consumer's self-determination. The OHCDS option also enhances the availability and responsiveness of the service delivery system for consumers and their families. (b) Any qualified provider of a waiver service may enroll directly with MO HealthNet as a Division of DD waiver provider. Providers are not required to provide services through an OHCDS arrangement. The OHCDS option allows consumers and families the ability to select and develop or train individuals they want to deliver services and care, thereby increasing the consumer's self-determination. The OHCDS option also enhances the availability and responsiveness of the service delivery system for consumers and their families. Completing the enrollment process through the MO HealthNet program can take time. Contracting with an OHCDS qualified entity may be an expedient way to get services started. The option expands provider choice for consumers and families. (c) Participants have free choice of qualified providers and are not required to access services through an OHCDS entity/arrangement. Providers are not required to contract with OHCDS entities, but may do so by choice. Qualified providers may enroll with MO HealthNet as a Waiver provider. (d) Provider agencies that have OHCDS designation have a specialized contract with the Department of Mental Health and with MO HealthNet. The agreement specifies the following: • Individual providers and agency providers are not required to contract with an OHCDS under the waiver.

	• All persons or agencies which do contract with an OHCDS to provide waiver services must meet the same requirements and qualifications as apply to providers enrolled directly with the Medicaid agency. • No OHCDS or contractor will be allowed to limit a recipient's free choice of provider. • Any state entity wishing to be designated an OHCDS must agree to bill the Medicaid program no more than its cost. • All contracts executed by an OHCDS, and all subcontracts executed by its contractors, to provide waiver services, must meet the applicable requirements of 42 CFR 434.6 and 45 CFR Part 74, appendix G. (e) MO HealthNet is responsible for enrolling all waiver providers as Missouri Medicaid providers. A standard provider qualification for each waiver provider is that the provider have an active contract to provide waiver services for the Division of DD. This contract is required along with other MO HealthNet provider enrollment forms and any other proof of license or other credential in order for the provider to enroll as a Missouri Medicaid provider of waiver services. In addition, Service Coordinators inform individuals of qualified providers and assist individuals in exercising choice. Regional Offices use the OHCDS option to expand choice by contracting or until the provider enrollment process is completed. (f) Regional Offices bill the same amount to MO HealthNet as the Regional Office paid the contract provider. The ~~**MO HealthNet Division's Program Integrity Unit (PI)**~~ ***Missouri Medicaid Audit and Compliance (MMAC)*** has the responsibility for reviewing paid claims. ~~**PI**~~ ***MMAC*** reviews paid claims by provider type or by specialty type if the provider type is too broad in scope. They randomly select a ~~**statistically valid**~~ sample within a set timeframe ~~**not to exceed three years prior**~~. Providers must maintain sufficient documentation to prove they provided services for which they were paid by MO HealthNet. In addition, all services are prior authorized to qualified providers, by Regional Offices. Service Coordinators monitor services to determine if the services authorized in the plan are being received and if the services are meeting the individual's needs.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

X	**The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
○	**The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.** Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.

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

APPENDIX I-4: Non-Federal Matching Funds

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**
X	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:
	a)The non-federal share is appropriated to Department of Mental Health, Division of DD from General Revenue and Mental Health Local Tax Fund. **b)The State utilizes Intergovernmental Transfers (IGT). Funds from any local government (County Boards) are deposited into the Mental Health Local Tax Fund with Division of DD, and expenditures for the State share for services in their county are made through Division of DD appropriations. MO HealthNet through the use of IGT directly accesses the Division of DD appropriations when making payments to providers. In addition, funds used for the state share for services delivered by private providers are also made through an IGT process from DMH general revenue appropriations.**
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

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

		a) Some Missouri Counties have passed laws that give them authority to levy taxes for residents who have developmental disabilities. Legislation which allows an individual county to create a local DD authority and through a vote of the citizens of the County collect a special tax levied on property up to 40 cents per hundred dollars valuation on property. RSMo 205.968-205.973 is the statutory reference. **b) The source of their revenue is the special tax on property.** **c) Funds from any local government (County Boards) are deposited into the Mental Health Local Tax Fund with Division of DD, and expenditures for the State share for services in their county are made through Division of DD appropriations. MO HealthNet through the use of IGT directly accesses the Division of DD appropriations when making payments to providers.**
	☐	**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:

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:*

X	**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-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.**
X	**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:

Rates for residential services do not include room and board charges. The provider has separate contract rates for Room and Board costs and residential habilitation. Room and Board and residential habilitation is based on a daily rate. Providers are reimbursed for room and board costs through a separate payment process. Room and Board is billed through separate procedure codes on a separate invoice from that of waiver residential habilitation. Room and Board is paid directly to the provider by Department of Mental Health using State only funds. No FFP is used for room and board.

EXPLANATION OF THE METHOD USED BY THE STATE TO EXCLUDE MEDICAID PAYMENT FOR ROOM AND BOARD

Rates for residential services and individualized supported living are negotiated between the provider and the Department of Mental Health in accordance with Department procedures and policies for rate setting. Rates are based on a daily rate. All rates are carefully reviewed to insure that room and board costs are separated and are not claimed for federal financial participation according to the following guidelines.

COSTS ELIGIBLE AND INELIGIBLE FOR
FEDERAL FINANCIAL PARTICIPATION - RESIDENTIAL SERVICES

	FFP ELIGIBLE/INELIGIBLE
PERSONNEL	
Wages and Salaries	***
Employee Benefits	Eligible
Social Security Contributions	Eligible
Retirement Contributions	Eligible
Insurance and Other Benefits	Eligible
Miscellaneous Personnel Expenses	Eligible
Staff Development	Eligible
Purchased Personnel Services	Eligible
Other Personnel Expenses	Eligible
OPERATING	
Occupancy	Ineligible
Rent	Ineligible

Utilities	Ineligible
Insurance	Ineligible
Housekeeping	Ineligible
Communications	***
Office Supplies	***
Treatment and Supportive Supplies	Eligible
Medical Supplies (not covered by Medicaid)	Eligible
Drugs (not covered by Medicaid)	Eligible
Food and Clothing	Ineligible
Habilitation Supplies & Equipment	Eligible
Transportation	Eligible
Staff Travel	Eligible
Client Transportation (As a separate billable cost)	Eligible
Purchased Treatment Services	Ineligible
Purchased Physician & Other Practitioners Services	Ineligible
Purchased Institutional & Other Facility Services	Ineligible
Purchased Laboratory Services	Ineligible
Miscellaneous Operating Expenses	
Library	Eligible
Debt Service	Ineligible
EQUIPMENT AND OTHER FIXED ASSETS	
Purchase of Assets	
Buildings and Land	Ineligible
Office Equipment	***
Medical Equipment	Ineligible
Other Equipment and Furnishings	Ineligible
Motor Vehicles	Eligible
Repairs and Improvements	
Building Repairs	Ineligible
Equipment and Furnishing Repairs	Ineligible
Motor Vehicle Repairs	Eligible

** Eligible/Ineligible - Clarification on eligibility/ ineligibility should be obtained from the Central Office. As a general rule, expenditures which are eligible and ineligible for FFP are specified in the DMH POS waiver contract. Room and board costs, furnishings, vocational and prevocational services, educational activities, and maintenance expenses are ineligible for FFP.

*** Eligible/Ineligible - The portion of these cost centers associated with waiver ineligible costs, and an equivalent resulting proportion of general and administrative costs, will be ineligible. Otherwise, these cost centers will be eligible.

APPENDIX 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.**
X	**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:
	The State allows the lead agency provider of Individualized Supported Living services to be reimbursed for the rent and food expenses of unrelated live-in caregivers, who reside in the consumer's home on a full time basis. (a) The method of establishing the cost of the caregiver's rent and food is to divide equally the collective rent and food costs of all persons living in the household, including the caregiver. This method is based on Section 4741(a) OBRA 1990, as explained in Section 4442.3 B. 12. of the State Medicaid Manual. Only the caregiver's share will be added to the lead agency's payment.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

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:*

X	**No. The State does not impose a co-payment or similar charge upon participants for waiver services.** (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.** (*Complete the remaining items*)

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*:

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

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	Basis

State:	
Effective Date	

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	**There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**
○	**There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.** Specify the cumulative maximum and the time period to which the maximum applies:

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:*

X	**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:

State:	
Effective Date	