



Missouri Home and Community-Based Services Settings Rule
Statewide Transition Plan
March 14, 2015
Amended July 27, 2016

Summary

In January 2014, the Centers for Medicare & Medicaid Services (CMS) published the federal Home and Community Based Services (HCBS) regulation, commonly known as the “HCBS Final Rule.” The purpose of the HCBS Final Rule is to ensure that Medicaid HCBS participants have the benefit of community living and the opportunity to receive services in the most appropriate, integrated setting possible. Since it was published, Missouri has been engaged in a thoughtful process to understand and meet the letter and intent of the HCBS Final Rule with its 10 Medicaid HCBS Waiver programs.

Missouri administers 10 Home and Community-Based Waivers through the single State Medicaid agency, the Department of Social Services, MO HealthNet Division (MHD). The day-to-day operation of the waivers is through formal cooperative agreements with the Missouri Department of Mental Health (DMH) and the Missouri Department of Health and Senior Services (DHSS). The Department of Health and Senior Services and the Department of Mental Health are the operational entities for the waivers. Missouri Medicaid Audit and Compliance (MMAC) is the unit within the Department of Social Services (DSS) charged with administering and maintaining Medicaid Title XIX audit and compliance initiatives, including utilization of Medicaid services and provider enrollment functions. MMAC will participate in the transition plan as described below.

The formal cooperative agreements outline specific duties related to the administration, operation and oversight functions of the waivers. MHD 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 MHD prior to submission to CMS. Any changes to a waiver program must be approved by MHD. 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 Statewide Transition Plan incorporates all 10 DHSS and DMH waivers and has been jointly developed by MHD, DMH and DHSS, herein referred to as the State. The transition plan as outlined below has sections that apply exclusively to waivers operated by DHSS, waivers operated by DMH, and those operated by both state agencies. It provides a high level overview of Missouri’s HCBS Medicaid programs, outlines the details of the steps taken to ensure compliance by March 2019, and outlines the public comment process which ensures input from self-advocates, families, advocacy organizations, and providers.

The MO Department of Mental Health operates the following 1915 (c) Waivers (DMH Waivers):

- Autism Waiver (MO.0698)
 - The Autism Waiver serves individuals between the ages of three and nineteen living in the community with family. The Autism Waiver provides assistive technology, behavior analysis services, community specialist, environmental accessibility adaptation, respite, personal assistance, person centered strategies consultation, professional assessment

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and monitoring, specialized medical equipment and supplies, support broker and transportation. The waiver objectives include: (1) Making available supplementary services, in the family owned or leased home and community, to assist families and other caregivers in understanding and managing challenging behaviors so children can continue to live in their own home and community and stay connected to community resources including school; (2) Making available community services that support the integration of children into the community so their experiences mirror those of their peers who do not have Autism Spectrum Disorder; and (3) Making available specialized, early intervention services to children who have been diagnosed with an autism condition so the participants have an opportunity to increase self-care, cognitive skills and social skills. These services are administered without restricting the participant's access to the community. The participants and their families are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraint. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

- **Comprehensive Waiver (MO.0178)**
 - This is the only waiver that provides residential supports. The waiver establishes and maintains a community-based system of care for individuals who have intellectual and developmental disabilities and includes a comprehensive array of services that meets the individualized support needs of individuals in a community setting. Although this waiver may serve individuals with residential supports, not all individuals enrolled in this waiver receive this service. Approximately 77% of the participants receive residential services. Others are living with their families but require substantial supports in order to continue doing so. These services are administered without restricting the participant's access to the community. The participants and their families are given choice of services and providers and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact. Participants in this waiver require the highest levels of care.

- **Missouri Children with Developmental Disabilities Waiver (MO.4185)**
 - The Missouri Children's Developmental Disabilities Waiver (MOCDD) allows certain State MO HealthNet eligibility requirements to be waived so that children targeted for participation may be determined MO HealthNet eligible. This waiver terminates on the individual's 18th birthday, the date on which the participant becomes eligible for Medicaid based on age. This waiver establishes and maintains a community-based system of care for children with developmental disabilities that includes a comprehensive array of services that meets the individualized support needs of children to allow them to remain at home with their families rather than enter an institution, group home or other out-of-home care.

- **Partnership for Hope Waiver (MO.0841)**

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- The Partnership for Hope Waiver prevents or delays institutional services for individuals who require minimal services in order to continue living in the community. The waiver offers prevention services to stabilize individuals living independently in the community or living with family members who provide significant support, but are not able to meet all of the individual's needs. The objectives of the waiver are: 1) to increase capacity of the State to meet the needs of individuals at risk of institutionalization who require minimal supports to continue living in integrated community settings; 2) to partner with local County Boards through Intergovernmental Agreements in the administration and funding of waiver services; and 3) to implement preventive services in a timely manner in order that eligible participants may continue living in the community with their families. The participants and their families are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraint. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
- Community Support Waiver (MO.0404)
 - The Support Waiver serves individuals who reside within their community, usually with family, but require other support services in order to remain in that living arrangement. Participants in this waiver have a place to live, but require supports so family members can continue employment and to give primary caregivers relief.

The MO Department of Health and Senior Services operates the following 1915(c) waivers (DHSS Waivers):

- Adult Day Care Waiver (MO.1021)
 - All services in the Adult Day Care Waiver (ADCW) are received and administered in an Adult Day Care. The ADCW provides adult day care for individuals age 18-63 with physical and other disabilities. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Aged and Disabled Waiver (MO.0026)
 - All services in the Aged and Disabled Waiver (ADW) are received and administered in the participant's home or in an Adult Day Care. The ADW provides adult day care, basic respite care, homemaker services, advanced block respite care, advanced daily respite care, advanced respite care, basic block respite care, chore services, home delivered meals, nurse respite for aged individuals ages 65 and over and for those who are physically disabled ages 63 and 64. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and

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restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

- AIDS Waiver (MO.0197)
 - The services in the AIDS waiver are received and administered in the participant's home, except attendant care which is provided in a residential care facility (Doorways/Cooper House). The AIDS waiver provides attendant care, private duty nursing, personal care, and supplies for individuals who are HIV positive and age 21 or over. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment and with whom to interact.
- Independent Living Waiver (MO.0346)
 - All services in the Independent Living Waiver (ILW) are received and administered in the participant's home. The ILW provides case management, personal care, Financial Management Services (FMS), environmental accessibility adaptations, and specialized medical equipment and supplies for physically disabled individuals ages 18-64. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
- Medically Fragile Adult Waiver (MO.40190)
 - All services in the Medically Fragile Adult Waiver are received and administered in the participant's home. The Medically Fragile Adult Waiver provides private duty nursing, waiver attendant care, and specialized medical supplies. These services are administered without restricting the participant's access to the community. The participants are given choice and are ensured the rights of privacy, dignity, respect and freedom from coercion and restraints. Participants are ensured individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

Missouri's Transition Plan work has focused on engaging stakeholders to be supported in exploring different avenues, learning experiences, and opportunities to know what is out in the community through education and training on rule requirements, as well as soliciting feedback on Missouri-specific approaches to assessments and compliance; building tools to assess HCBS Final rule compliance among HCB settings and for State regulations, policies, and procedures; utilizing those tools to assess HCB settings; and mapping a path to work toward full compliance by March 2019 and beyond.

MHD submits this amended Statewide Transition Plan in accordance with requirements set forth in the CMS HCBS Final rule released on January 16, 2014 (see 42 C.F.R. § 441.301(c)).

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This amended Statewide Transition Plan builds on the originally proposed Statewide Transition Plan submitted on March 14, 2015. This plan includes information submitted in response to the CMS Letter of Reaction, and further details about settings and assessment validation based on conference calls held with CMS on September 15, 2015, and March 17, 2016. Additionally, it reflects guidance that continues to be issued by CMS, including but not limited to the Settings Requirements Compliance Toolkit and the HCBS Training Series Webinars Presented During SOTA Calls (Home and Community-Based Settings, Excluded Settings, and the Heightened Scrutiny Process – November, 2015; and Home and Community-Based Setting Requirements: Systemic and Site-Specific Assessments and Remediation – December, 2015). Due to the need to renew the DHSS Adult Day Care and Medically Fragile Adult Waivers and amend the DMH Community Support and Partnership for Hope Waivers, MHD submitted and received approval for Transition Plans specific to each waiver application. Transition Plan activities were designed to lead to both a waiver-specific Transition Plan for each waiver program as well as a Statewide Transition Plan (STP). Missouri's originally proposed STP and approved waiver-specific Transition Plans differ from this amended STP in the areas specified below:

- Structure of the STP: The format of the STP was changed from a table format to a narrative format, as well as clearly separating sections that apply exclusively to waivers operated by DHSS and those operated by DMH. It includes further descriptions and indication of setting types for each of the 10 waivers, and further clarification of the operating structure of DHSS waivers.
- Section 1: Assessment: This amended STP provides more detail on the following components:
 - General Settings categories with estimated number of settings falling under each category
 - Determination of Heightened Scrutiny settings,
 - Assessment tool development,
 - Systemic Initial On-Site Assessment process including amounts and process of on-site assessments performed,
 - On-going monitoring through incorporating the HCBS requirements into existing quality integrated functions, and
 - Provider self-assessment and participant survey development.
- Section 2: Remediation Strategies: This amended STP provides more detail on the following components:
 - Code of State Regulations Review and Rule filing, including a crosswalk to the HCBS final rule,
 - Incorporating HCBS final rule into
 - Provider Manuals and Provider Enrollment processes,
 - provider meetings and trainings;
 - processes for provider remediation and status updates,
 - on-going compliance reviews, provider sanctions; and
 - individuals transitioning to settings that align with HCBS Requirements
- Section 3: Public Comment: This amended STP provides more detail on the following components:
 - Incorporating new public comment processes and periods

Section 1: Assessment

The State used a multi-faceted approach to assessment. This approach included a review of state regulations, policies, procedures, provider manuals, enrollment processes and tools, provider review processes and quality review tools. It also included the development and completion of a settings analysis, provider self-assessment and participant survey. The detailed assessment processes are described below. Assessment activities will be incorporated into current quality assurance processes to the extent possible.

Missouri Code of State Regulation (CSR) Assessment

MHD requested DMH and DHSS to review all state regulations to determine their compliance with the HCBS Final rule and if revisions are needed to reflect federal regulations on HCBS settings. This review process took place between October 1, 2014 and March 1, 2015 and continues as needed. DMH and DHSS developed a crosswalk documenting their assessment of state regulation compliance with the HCBS Final rule. The crosswalks documents the following information: state regulations; applicable federal requirements; compliance status (compliant, partially compliant, non-compliant or silent); changes needed to bring language into compliance; remediation activities the state will take to bring regulation(s) into compliance; and milestone dates. MHD reviewed each crosswalk and evidence of compliance to ensure that all aspects of the system are congruent with CMS expectations and will allow the State to operate HCBS programs in a manner that comports with the HCBS Final rule. This assessment process involved reviewing state regulations concerning MHD, DMH, and DHSS located in: Missouri 13 CSR 70, Missouri 13 CSR 65-2, Missouri 9 CSR 45, Missouri 19 CSR 15, Missouri 19 CSR 30-81, and Missouri 19 CSR 30-90.

- DMH Waivers:
 - DMH's systemic CSR review included regulations concerning licensure and certification, provider enrollment, prioritizing access to funded services, the utilization review process, due process, standards for community-based services, individualized habilitation plan procedures, advisory councils for DMH departments authorized to license Medicaid-reimbursed HCBS settings. <http://dmh.mo.gov/dd/hcbs.html>
 - DMH initiated ongoing internal strategy meetings to assess all rules and regulations. Additionally, DMH obtained consumer and family, provider, advocate, and other stakeholder input into revisions necessary based on the self-assessment of state standards, requirements and practices. DMH presented revisions to consumers, families, caregivers, providers, advocates, and other stakeholders via postings and comment periods. During these comment periods, DMH asked for stakeholder input on the development of the rules, regulations, policies, protocols, and practices. Instructions for providing input were included in the notices.

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- **DHSS Waivers:**

DHSS's systemic CSR review included regulations concerning licensure, provider enrollment, and standards for community-based services. DHSS also reviewed all waiver policies and manuals. The crosswalk can be found at:

<http://health.mo.gov/seniors/hcbs/transitionplan.php>

Provider Manuals, Policies, and Procedures Assessment

MHD requested DMH, DHSS, and MMAC to review all manuals, policies, and procedures to determine their compliance with the HCBS Final rule and if revisions are needed to reflect federal regulations on HCBS settings. This review process began on January 1, 2015 and will be completed December 31, 2016. DMH and DHSS developed a crosswalk documenting their assessment of provider manuals, policies, and procedures compliance with the HCBS Final rule. The crosswalk documents regulations that are (a) compliant, and evidence of that compliance; (b) where modifications are needed to achieve compliance, or (c) silent. The crosswalks included the following information: state regulations; applicable federal requirements; compliance status (compliant, non-compliant or silent); changes needed to bring language into compliance; remediation activities the state will take to bring provider manuals, policies, and procedures into compliance; and milestone dates. MHD reviewed each crosswalk and evidence of compliance to ensure that all aspects of the system are congruent with CMS expectations and will allow the State to operate HCBS programs in a manner which comports with the HCBS Final Rule. Results of the crosswalk are posted online at <http://dmh.mo.gov/dd/hcbs.html> and <http://health.mo.gov/seniors/hcbs/transitionplan.php>.

Missouri HCBS Waiver Participant Survey

The State developed initial participant surveys between November 1, 2014 and December 31, 2014. The surveys were developed utilizing a modification of the CMS exploratory questions along with input from self-advocates. The surveys collected individual experiences to determine if service settings were in compliance with the HCBS Final rule. The surveys included identification of the setting type, so the State could utilize this information in follow-up to the setting. The surveys provided the option for anonymity or to include contact information if participants wished to have follow-up communication with the State. The State did an on-site assessment if requested, or if it was determined there was a need for one, based on the information provided.

DMH distributed participant surveys through a variety of sources, such as on-line at <http://dmh.mo.gov/dd/hcbs.html>, through its DMH Support Coordinators, at a variety of stakeholder conferences (People First, MACDDS and Real Voices, Real Choices), and stakeholder list serves (Partners in Policy Making). Results of the initial survey are posted on-line at <http://dmh.mo.gov/dd/hcbs.html>.

DHSS mailed a survey to all participants receiving adult day care services. The surveys included postage-paid return envelopes. The survey is also available on the DHSS Settings website at: <http://health.mo.gov/seniors/hcbs/transitionplan.php>. DHSS also hand delivered, through HIV Case Managers, surveys to individuals receiving attendant care services through the AIDS waiver.

On an ongoing basis, questions posed from the participant surveys will be incorporated into annual assessments and reviews.

- **DMH Waivers**

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- DMH Quality Enhancement team incorporated Home and Community Based federal rules into the annual review process. The Quality of Services Review prescribes a standardized procedure to ensure the individual has full access to benefits of community living and the opportunity to receive services in the most appropriate integrated setting; assess the person-centered planning process; and provide feedback to the interdisciplinary team about utilizing key points of self-determination:
 - Individuals will live a meaningful life in the community and be empowered in making life decisions.
 - Individuals will have support to organize resources in ways that are life enhancing and assist them in reaching their dreams and goals. Individuals have a circle of supports made up of family, friends, and both paid and unpaid supports.
 - Individuals assume responsibility for giving back to their community, for seeking employment, and for developing unique gifts and talents.
 - Individuals are recognized for who they are and what they can contribute.
 - Enhancing identified areas (values, choice, health, safety, inclusion, self-advocacy)

Reviews are conducted related to quality indicators based on the HCBS rule, Missouri Quality Outcomes <http://dmh.mo.gov/dd/docs/missourqualityoutcomes.pdf>, National Core Indicators <http://www.nationalcoreindicators.org/indicators/>, and 9 CSR 45-5.010 Certification of Medicaid Agencies Serving Persons with Developmental Disabilities.

- DMH incorporated Home and Community Based federal rules into the annual planning process utilized for all DMH HCBS waivers. The annual plan shall be face-to-face with the participant utilizing the Individual Support Plan Guide (<http://dmh.mo.gov/dd/manuals/docs/ISPguide.pdf>) and Medicaid Waiver, Provider, and Services Choice Statement (<http://dmh.mo.gov/docs/dd/h15wvrchoiceform.doc>) to establish continued HCBS services and compliance with the HCBS Settings Rule.
 - The Individual Support Plan (ISP) Guide is a comprehensive guide to care and service planning in community-based settings. It focuses on the individual's strengths, capacities, preferences, needs and personal outcomes which include a personalized mix of paid and non-paid services and supports that will assist the person to achieve personally defined outcomes. Additionally, this guide has been updated to match the new Missouri Quality Outcomes, which were updated August 2015. The Missouri Quality Outcomes (MOQO) were developed to emphasize quality of life for individuals receiving services and supports; they are key to facilitating discussion during the Person Centered Planning process and developing the ISP. MOQO includes the different life domains that everyone experiences as we age and grow. Everyone (whether they have a disability or not) has to decide: what they are going to do during the day—go to school, volunteer or get a job; where they are going to live; how they are going to stay healthy and safe; and etc.
 - The ISP and Medicaid Waiver, Provider, and Services Choice Statement provides documentation of the individual's involvement in care planning by including the individual's acknowledgement and outcome of his/her:
 - Participation in the development of the ISP
 - Right to have anyone involved in the development of the ISP

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- Right to choose and receive HCBS (State Plan and/or Waiver) or institutional care
 - Right to choose the HCBS provider
 - Right to Due Process
- DHSS Waivers
 - Adult Day Care Setting. The participant survey utilized by the Division of Senior and Disability Services (DSDS) was an information gathering tool for initial guidance on participant perspective regarding the compliance of the adult day care setting with the elements of the HCBS Final Rule and will be incorporated into the annual reassessment on an on-going basis. The participant survey report can be found at: <http://health.mo.gov/seniors/hcbs/transitionplan.php> .
 - All participants authorized for HCBS shall have a reassessment completed within 365 days of the last level of care determination. For participants receiving an Adult Day Care service, DSDS or its designee shall perform face-to-face reassessments with the participant utilizing the InterRAI HC and the HCBS Care Plan and Participant Choice Statement (DA-3) to establish continued eligibility of services and compliance with the HCBS Settings Rule.
 - The InterRAI HC guides comprehensive care and service planning in community-based settings. It focuses on the person's function and quality of life by assessing needs, strengths, and preferences.
 - The HCBS Care Plan and Participant Choice Statement (DA-3) is completed at each initial and subsequent face-to-face reassessment and used to determine eligibility for HCBS. As a component of the person centered care planning process the DA-3 provides documentation of the participant's involvement in care planning by including the participant's acknowledgement and outcome of his/her:
 - Participation in the development of the person-centered care plan –to include both formal and informal services identified to live successfully in the community
 - Right to have anyone involved in the development of the person centered care plan
 - Right to choose and receive HCBS (State Plan and/or Waiver) or nursing facility care
 - Right to choose the HCBS provider
 - Need to Notify the DHSS's Central Registry Unit (CRU) to report abuse, neglect, or exploitation
 - Need to notify the appropriate DSDS Regional Evaluation Team of any problems concerning service delivery as well as changes in health, formal and informal supports, satisfaction with the services provided, and/or functioning status that might require care plan adjustment
 - Discriminatory behavior regarding service delivery

The InterRAI HC assessment and the HCBS Care Plan and Participant Choice Statement (DA-3) fulfill the non-residential requirements set forth in:

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42 CFR 441.301(c)(4)(i)/441.710(a)(1)(i)/441.530(a)(1)(i)

42 CFR 441.301(c)(4)(ii)/ 441.710(a)(1)(ii)/441.530(a)(1)(ii)

42 CFR 441.301(c)(4)(iii)/ 441.710(a)(1)(iii)/441.530(a)(1)(iii)

42 CFR 441.301(c)(4)(iv)/ 441.710(a)(1)(iv)/441.530(a)(1)(iv)

42 CFR 441.301(c)(4)(v) 441.710(a)(1)(v)/441.530(a)(1)(v)

- AIDS Waiver. The survey will be released annually January 1 through December 31 with results compiled and a report issued by March 1st. All participants will be mailed a survey, which will include a postage-paid return envelope. The survey will also be available on the DHSS website at:
<http://health.mo.gov/seniors/hcbs/transitionplan.php> .
- All other waiver settings are considered compliant, because participants live in their own homes. Therefore, surveys will not be released for those settings unless information is received that the setting may be institutional in nature.

Provider Self-Assessments

On June 23, 2014, the State posted a Provider Bulletin on the MHD website, regarding the HCBS Final rule, including a link to the CMS HCBS website. The bulletin included information alerting providers to a future provider self-assessment survey. The State developed initial provider self-assessment surveys between June 23, 2014 and August 22, 2014 by incorporating the CMS exploratory questions into an on-line survey. Via Provider Bulletin on August 22, 2014, MHD requested HCBS Waiver providers complete an initial provider self-assessment survey by September 10, 2014. In an effort to assist providers with the completion of the provider self-assessments, the State released the “Missouri Exploratory Questions for Assessment of HCBS Waiver Settings” document to assist providers in identifying if services are integrated in and participants 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. In addition, links to the provider self-assessment surveys were posted on the DMH website for provider access. DMH and MMAC performed on-site assessments on all providers that completed an initial self-assessment to validate responses.

MHD requires DMH and DHSS to monitor the self-assessment process for each agency and utilize the process for ongoing compliance efforts. This process began on October 1, 2014, and its design was completed by both agencies by February 1, 2015. This process will continue on an ongoing basis.

- DMH waivers:
 - A provider self-assessment survey was developed 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.
 - As a result of provider feedback, DMH developed a Provider Survey Self-Assessment Companion Guide to offer further explanation of the Home and Community Based Setting Requirements. This companion guide follows the On-site Assessment Tool.
 - The provider self-assessment is available on the DMH website for all prospective and currently enrolled providers to utilize at any time (<http://dmh.mo.gov/dd/hcbs.html>).

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- DMH will re-post the provider self-assessment survey and the Provider Survey Self-Assessment Companion Guide to the DMH website annually on January 1 and encourage providers to complete the provider self-assessment by April 1, with results compiled by May 15.
 - DMH will receive any completed annual provider self-assessment and maintain them in the providers' files.
 - Components of the provider self-assessment tool have been incorporated into tools utilized when DMH completes provider monitoring and certification. DMH completes a Provider Relations review every three years. Certification occurs every two years when applicable.
 - DMH will review any submitted provider self-assessments prior to provider relations reviews to determine if there are any potential compliance issues. DMH provider relations reviews occur every three years for specified services.
 - DMH will review any submitted provider self-assessment in conjunction with the provider's DMH generated annual trend report to determine if there are any potential compliance issues. Any discrepancies will be followed up by the means necessitated by the level of concern (e.g. provider technical assistance, an on-site visit with the provider, placement on a provider improvement plan.)
 - DMH will utilize the provider self-assessment as a training tool annually at Regional provider meetings.
- DHSS Waivers:
 - MMAC will continue to assess providers on an ongoing basis, including continued utilization of the Provider Self-Assessment. The provider self-assessment will continue to be utilized in the following ways:
 - The provider self-assessment is available on the MMAC website at <http://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/> for all prospective and currently enrolled providers to utilize at any time.
 - The provider self-assessment will be utilized as a pre-enrollment screening tool when MMAC conducts pre-enrollment on-site visits of Adult Day Care providers and AIDS Waiver Attendant Care providers.
 - The provider self-assessment will be utilized as a regular tool when MMAC conducts post-payment reviews of Adult Day Care and AIDS Waiver Attendant Care providers. MMAC conducts post-payment reviews of enrolled HCBS providers at least every three (3) years.
 - The provider self-assessment will be utilized as a regular tool when MMAC conducts revalidation efforts for Adult Day Care and AIDS Waiver Attendant Care providers. MMAC revalidates providers every five years.
 - In addition, MMAC will utilize the provider self-assessment when it is on-site with an Adult Day Care or AIDS Waiver Attendant Care provider for other reasons such as investigations, and
 - MMAC will utilize the provider self-assessment as a training tool every six months at Provider Update Training.
 - MMAC will compare providers' self-assessments and any MMAC observations with participant responses to DHSS' participant assessments and surveys. Any

discrepancies will be followed up by the means necessitated by the level of concern (e.g. an on-site visit with the provider, an audit of the provider's billing and practices, or an investigation.)

Settings Analysis

Prior to conducting on-site assessments, the State identified HCBS Waiver settings used by waiver participants. The state conducted a preliminary analysis of these various settings. This Settings Analysis was general in nature and did not imply that any specific provider or location was noncompliant solely by classification. Final determination depends upon information gathered through all assessment activities outlined in the transition plan. Please note: residential habilitation settings include Group Home, Individualized Supported Living (ISL), and Shared Living. Non-residential settings include Day Habilitation and Employment.

Settings Assessed:

- DMH Waivers:
 - Residential Habilitation, only provided in the Comprehensive Waiver
 - Employment Services, only provided in the Comprehensive, Community Support, and Partnership for Hope Waivers
 - Day Service, provided in all waivers except Autism Waiver (Community and Facility Based Day, and In-home Day)
 - Family Model Residential Support (Host Home), only provided in the Comprehensive Waiver
 - Individualized Support Living, only provided in the Comprehensive Waiver
- DHSS Waivers:
 - Adult Day Care, provided in the Adult Day Care and Aged and Disabled Waivers
 - Attendant Care in a Residential Care Facility, provided in the AIDS waiver

General settings are classified into the following categories:

- **Yes - Settings presumed fully compliant with HCBS characteristics.** The State considers settings where individuals own or lease their homes, or reside with family as fully compliant unless information is provided that would lead the State to believe the setting is institutional in nature. The State would then move the setting to the Heightened Scrutiny review. It is assumed that approximately 83% of the individuals in these DMH settings will fall under this category; Approximately 13,269 DHSS settings will fall into the "Yes" category.
- **Not Yet - Settings may already be compliant, or with changes will comply with HCBS characteristics.** The State considers settings where individuals reside in provider-owned or controlled housing of any size, reside in a staff member's home, adult day care program settings, or receive services in a day program setting located in a building that also provides other disability-specific services as not yet compliant but may be with changes. It is assumed approximately 17% of the individuals in these DMH settings will fall under this category. It is anticipated that approximately 79 DHSS provider settings will fall under this category.
- **Not Yet - Settings presumed non-HCBS but evidence may be presented to CMS for heightened scrutiny review.** The State considers settings located in a building that also provides inpatient institutional treatment, any setting on the grounds of or adjacent to a public institution, or

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settings that isolate participants from the broader community, such as multiple locations on the same street operated by the same provider (including duplexes and multiplexes) to be not yet compliant, but evidence may be presented to CMS for heightened scrutiny review when the State further evaluates and determines that the setting does meet the qualities for home and community based settings. Approximately 140 providers with 152 settings (physical addresses) through DMH will fall under this category; 34 settings (physical addresses) through DHSS may fall under this category; and

- **No – Settings that do not and cannot meet HCBS characteristics.** The state considers settings located in Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) (except Respite), Nursing Facilities/Skilled Nursing Facilities, Hospitals and Institutions for Mental Disease (IMD) to not be compliant. Out of home respite and Temporary Residential services provided in an ICF/ID or State Habilitation Center cannot exceed 30 days consecutively.

Heightened Scrutiny Evaluation of HCBS Service Settings and Addresses

MHD worked with DMH and DHSS to develop agency processes to identify HCBS Settings and Addresses for Heightened Scrutiny based on the CMS Heightened Scrutiny process:

<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/settings-that-isolate.pdf> .

The agency processes will help the State to determine whether such settings in fact should be “presumed to have the qualities of an institution,” and if so, will require submission of evidence to CMS in order to demonstrate that the setting does not have the qualities of an institution and that it does have the qualities of a home and community-based setting. The State will review data pertaining to:

- services utilized by individuals receiving services in the setting;
- amount of time spent in such setting;
- on-site visits and assessments of physical location and practices;
- review of the person-centered plans;
- interviews with individuals to understand their experiences when receiving services in the settings;
- review of providers policies, trainings, and other applicable service related documents;
- and a review of the provider’s proposed transition plan, including the timeline and impact of the proposed changes.

The State does not intend to submit to CMS for application of Heightened Scrutiny unless the State believes that the setting in fact has the qualities of a home and community based setting, which may include steps that will be taken by the provider as part of an approved transition plan with providers to review specified settings for compliance with the HCBS Settings Rule using the process defined by CMS. The State will engage stakeholders, advocacy organizations, and providers in the review process. The state will further evaluate and continue to work with providers on any setting that may be institutional in nature – by virtue of physical location, or because it is designed specifically for people with disabilities and individuals in the setting are primarily or exclusively people with disabilities and the on-site staff that provide services to them. Per CMS, evidence of how a setting overcomes its presumed institutional qualities should focus on the qualities of the setting and how it is integrated in and supports full access of individuals receiving HCBS into the greater community.

- DMH waivers

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- MHD worked with DMH and the state's Office of Administration beginning October 16, 2014 to develop a Geographic Information System (GIS) report that layers provider and participant addresses across all agencies. Provider types include HCBS waiver providers such as residential, day services, adult day care, aged and disabled, and employment. It also includes hospitals, nursing homes, and state operated institutions. Service Setting addresses included in this mapping are the DMH sites licensed or certified by the department's Licensure and Certification Unit, Department of Health and Senior Services Nursing facilities, public institutions, Residential Care Facilities, Assisted Living Facilities, and DMH providers accredited through Commission on Accreditation of Rehabilitation Facilities (CARF) and deemed certified through DMH. The GIS system was completed by March 30, 2015.
- DMH will use GIS to analyze locations of individuals' service settings (co-located and operationally related within 1/8 mile) and settings that provide individuals multiple HCB services in one location and address to identify potential settings that isolate or are institutional in nature.
- DMH has identified approximately 140 providers with 152 settings of HCBS heightened scrutiny settings through the GIS mapping. Settings are categorized by the three (3) heightened scrutiny categories below.
 1. Zero (0) providers with settings located in or adjacent to a publicly or privately owned- facility that provides inpatient treatment.
 2. Eight (8) providers with eight (8) setting locations on the grounds of, or immediately adjacent to, a public institution. Two providers with two settings provide residential services within 1/8 of a mile of a public nursing home. Six providers with six settings provide residential services on the same grounds or immediately adjacent to state schools for the disabled or blind.
 3. One hundred thirty-two (132) providers with 144 setting locations appear to have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.
 - Twenty (20) providers with 21 settings providing multiple DMH HCB services in one location (residential & non-residential by the same provider). Individuals in these settings receive residential services while also receiving services such as day services, community integration, and employment services in the same location.
 - Five (5) providers with nine (9) settings providing multiple DMH HCB services in one location (residential & residential by the same provider). Individuals in these settings receive residential services in apartments or duplexes.
 - Seven (7) providers with 12 settings providing multiple DMH HCB services within 1/8 of a mile (residential & non-residential). Individuals in these settings receive residential services within 1/8 mile of service settings such

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as day services, community integration, and employment services by the same provider.

- Ninety-six (96) providers with 96 settings providing multiple DMH HCB services within 1/8 of a mile (residential & residential by the same provider). Individuals in these settings receive residential services within 1/8 mile of other individual(s) receiving residential services by the same provider.
- Four (4) providers with six (6) settings providing HCB waiver services within the same building (DMH & Adult Day Care by the same provider). Individuals in these settings are receiving DMH Day Habilitation services within the same building as DHSS Adult Day Care waiver services.
- Heightened Scrutiny addresses and evidence packages will be posted for public comment and shared with CMS. Per CMS, evidence of how a setting overcomes its presumed institutional qualities should focus on the qualities of the setting and how it is integrated in and supports full access of individuals receiving HCBS into the greater community.
- DHSS Waivers
 - DHSS gathered information through licensure records to determine which Adult Day Care (ADC) settings were located on the grounds of or adjacent to an institutional setting. DHSS identified seven Adult Day Care Centers located on the grounds of or adjacent to an institutional setting. Upon further clarification and guidance from CMS, DHSS reexamined the Heightened Scrutiny information gathering process. Utilizing the GIS system that DMH used in cooperation with MHD and the state's Office of Administration, DHSS was able to identify ADCs that were unidentified in the previous information gathering process. Beginning October 16, 2014, the State developed a GIS system that layers provider and participant addresses across all agencies. Provider types include HCBS waiver providers such as residential, day services, adult day care, aged and disabled, and employment. It also includes hospitals, nursing homes, and state operated institutions. Service Setting addresses included in this mapping are DHSS sites licensed or certified by the department's Regulation and Licensure Unit, Department of Health and Senior Services Nursing facilities, public institutions, Residential Care Facilities, Assisted Living Facilities, and DMH providers accredited through CARF and deemed certified through the DMH. The GIS system was completed by March 30, 2015.
 - DHSS will use GIS to analyze locations of individuals' service settings (co-located and operationally related within 1/8 mile) and settings that provide individuals multiple HCB services in one location and address to identify potential settings that isolate or are institutional in nature.
 - DHSS has identified approximately 34 settings that appear to have one or more qualities requiring further review.

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- The 34 providers requiring further review are first subject to a Heightened Scrutiny Review by MMAC:
 - MMAC will review the 34 providers, ensuring the settings have overcome the presumption of having institutional qualities, yet still fall into one of the “three prongs” for settings presumed not HCBS.
 - MMAC will contact those providers to educate them about the Heightened Scrutiny process.
 - MMAC will collect and coordinate any participant information provided to them by DHSS.
 - MMAC will determine if any of the settings reviewed under any of the three prongs should be elevated to Heightened Scrutiny to CMS, along with an evidentiary package, for review, based upon the following criterion: Did MMAC determine after its review that the provider does not fit any of the three prongs? If the provider still falls under one or more of the three prongs, it will be elevated to CMS for heightened scrutiny review.
- MMAC Heightened Scrutiny Review process will include:
 - Determining if the setting is integrated in the community to the extent that the persons without disabilities in the same community would consider it a part of their community and not associate the setting with the provision of services to person with disabilities.
 - Determining if individuals participate regularly in typical community life activities outside the setting to the extent the individuals’ desire.
 - Determining if the setting is co-located with other settings and operationally related to those other settings (owned and operated by the same provider) in such a fashion that individuals’ ability to interact with the broader community is limited.
 - Determining if the services provided to the individuals, and the activities in which the individuals participate, are engaged with the broader community.
 - MMAC will review data to which it has access regarding the billing for and provision of services and compare this to any information otherwise available regarding the setting as a whole.
 - MMAC will conduct a follow up site visit and further assess, in person, the physical location and practices.
 - MMAC will receive and coordinate any follow up interviews with participants conducted by DHSS, and any follow up review of participant person-centered care plans conducted by DHSS.
 - MMAC will work closely with the provider(s) and their individual transition plan(s) every six months or more frequently if necessary.
- Heightened Scrutiny Review:
 - MMAC will submit evidence to CMS regarding the identified providers who “passed” internal scrutiny review and why, and why they are not being referred for heightened scrutiny review

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- For those providers who do need to be elevated to CMS for heightened scrutiny review, MMAC will submit types of evidence to CMS to demonstrate that the setting(s) does not isolate individuals receiving HCBS from the broader community of individuals not receiving HCBS, and
 - MMAC believes the setting can be brought into full compliance by March 2019; and
 - MMAC has demonstrated that persons receiving services are not isolated from the greater community of persons not receiving HCBS
 - MMAC has demonstrated that there is strong evidence the setting does not meet the criteria for a setting that has the qualities of an institution.
 - MMAC's rationale shall focus on qualities of the setting and how it is integrated in and supports full access of individuals receiving HCBS into the greater community, and strategies the setting has implemented to rectify and fully overcome its former institutional qualities or characteristics that isolate participants. MMAC's rationale shall not focus on the aspects and/or severity of the disabilities of the individuals served in the setting, or why isolating or institutional qualities or characteristics are justified.
 - MMAC's rationale may include observations from on-site review(s), licensure requirements or other state regulations, proximity to/scope of interactions with community settings, provider qualifications for HCBS staff, documentation in the person-centered care plan that the individuals' preferences and interests are being met, evidence that that individuals chose their setting, and details of proximity to public transport or other transportation strategies to facilitate integration, and pictures of the site and any other demonstrable evidence. Site visits should focus on the individuals' experiences and the presence or absence of qualities of home and community based settings.
 - MMAC will include the full name, location and evidentiary package of each setting to be submitted for CMS review so that public comment information may be added prior to inclusion in the STP and prior to submission to CMS for heightened scrutiny review.
 - MMAC will respond accordingly with the provider(s) following CMS response. If the setting does not comply, providers will be afforded the opportunities outlined by CMS, to include implementing necessary modifications by the end of the transition period, furnishing Medicaid services that do not require their provision in an HCB setting, or being recognized as an institution.
- Heightened Scrutiny addresses and evidence packages will be posted for public comment and shared with CMS. Per CMS, evidence of how a setting overcomes its presumed institutional qualities should focus on the qualities of the setting and how it is

integrated in and supports full access of individuals receiving HCBS into the greater community.

Initial Settings Assessment Tool Development

MHD required the operating agencies to develop an initial assessment tool to be used by designated state staff for the initial on-site assessments. DMH and DHSS were required to begin this process on February 1, 2014 and complete it by December 15, 2014.

- DMH Waivers
 - The DMH Assessment Tool incorporates CMS Exploratory questions for Residential and Non-Residential Settings (<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-re-settings-characteristics.pdf> and <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-non-residential.pdf>) and Missouri exploratory questions (<http://dmh.mo.gov/docs/dd/moexploratoryquestions.pdf>) to develop the Initial Setting Assessment Tool. The DMH Assessment Tool may be found at <http://dmh.mo.gov/docs/dd/onsiteassessmentinstrument.pdf>.
 - DMH staff received training on administering the tool prior to conducting on-site reviews.
 - The Assessment tool includes residential, provider owned and controlled residential, non-residential, and heightened scrutiny sections that specifically reference the HCBS Setting Rule.
- DHSS Waivers
 - MMAC's Assessment Tool was based on CMS exploratory questions as related to the specific requirements under the regulation. MMAC's initial settings assessment tool is titled "Home and Community Based Setting Survey". The tool will be used during the initial on-site survey of all Adult Day Care Centers and Doorways/Cooper House (AIDS Waiver Attendant Care provider). The MMAC tool may be found at <http://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/>.
 - MMAC personnel designed and received in-house training regarding the tool and how to utilize it during on-site visits.

Initial On-Site Assessment

MHD required the operating agencies to develop a process and to assess a statistically valid sample of HCBS settings to determine current status of compliance with the HCBS Final rule. Assessments began on December 16, 2014 and were completed by April 1, 2016.

- DMH Waivers
 - DMH identified HCB Waiver service settings through three components. The first component was the identification of providers and settings through the provider self-assessment submitted. In addition to validation of 100% of the provider self-assessments, the second component was the development of a random sample pull of individuals receiving HCB waiver services through the five DMH HCBS waivers. The third

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component was the identification of DMH HCB Waiver service settings considered heightened scrutiny (qualities of an institution or effect of isolating individuals) through GIS mapping.

- A statistically valid sample size of settings (based on 95% confidence level) was utilized for assessment using the RAOSoft Sample Size Calculator program.
 - This statistically valid sample with the 95% confidence level calculates to approximately 930 on-site assessments out of approximately 2,200 service sites.
 - In addition to the random sample pull and GIS identified Heightened Scrutiny settings, individuals and providers requested and still may request DMH to conduct on-site assessments through the participant and provider surveys.
 - As a result of the random sample, Heightened Scrutiny, and requested assessments, DMH initiated assessments for 1,044 individuals. This amount could decrease due to individuals no longer receiving services; individuals choosing not to participate in assessments; a provider's terminated contract; death; etc.
 - DMH staff conducted on-site, face-to-face assessments with individuals, guardians, and others chosen by the individual utilizing the DMH Assessment Tool (<http://dmh.mo.gov/docs/dd/onsiteassessmentinstrument.pdf>). The assessment process included review of the Individual Support Plan (ISP); consideration of the individual's perspective of choice, full access to the community, and quality care; observation of the setting; and information from direct care staff, support coordinators, and providers. Individuals were able to decline an assessment, which is noted on the assessment tool.
 - As assessments were completed for individuals served, DMH staff developed a summary of findings for each individual assessed (including requirements for remediation) and distributed the summary to the individual, the service provider, and the support coordinator within 45 calendar days of the completed on-site assessment.
 - Settings found to need consideration of a state request to CMS for Heightened Scrutiny were given priority of review by DMH.
 - Data collected from the assessments were included in a database to analyze at various levels such as provider, setting type, individual, and region.
 - Please see the HCBS Waiver Settings Assessment Findings and Provider Individual Remediation milestones under the Remediation Strategies Section for more details.
- DHSS Waivers
 - MMAC completed on-site visits of all 112 Adult Day Care providers and Doorways/Cooper House (AIDS Waiver Attendant Care provider) by April 1, 2016. 100% of these providers were contacted in person (the on-site visit) due to the small number.
 - MMAC reviewed all the completed assessments (surveys) done on-site and prepared a report of the findings.
 - The report was posted to the MMAC website.
 - Participant surveys results were reviewed based on provider information and will be attached to the provider surveys, and a second review conducted to determine consistencies/inconsistencies and identify any issues that require further review.
 - MMAC will create an addendum to the report. This addendum will incorporate the second review conducted.
 - MMAC will provide results to 100% of the Adult Day Care and AIDS Waiver Attendant Care providers via US Mail, including a self-addressed, postage-paid return envelope. Providers will be requested to submit feedback regarding areas of non-compliance,

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including individual transition plans that explain how the provider will become compliant

- Provider responses will be maintained, tracked, and compiled by MMAC.
- MMAC will assist providers that request assistance in their efforts to become compliant. MMAC has a team of personnel who work exclusively with HCBS providers, as well as three enrollment personnel who work exclusively with enrolling HCBS providers. Provider responses will be reviewed and addressed on a semi-annual basis. This will allow the state ample time to assist providers with any necessary compliance efforts/remediation needs by 2019.

Assessments Results Report

The state will compile and analyze findings of initial assessments and surveys by December 31, 2016. Findings will be presented to CMS, state leadership and stakeholders. Additionally, DHSS will compile and analyze participant survey results by Adult Day Care and in the aggregate. Based on these findings, the state will follow-up as appropriate. DHSS will provide results of the participant surveys to MMAC.

Provider Enrollment Process Assessment

MHD required DMH and DHSS to operationalize mechanisms to incorporate assessment of settings into existing processes for provider enrollment. This process began on November 14, 2014 and was implemented on March 2, 2015.

- DMH Waivers:
 - DMH posted information about the Final Rule and setting requirements on its website for all prospective and newly enrolling providers.
 - DMH included information about the Final Rule in its Frequently Asked Questions document, distributed to all newly enrolling providers and posted on the DMH website (<http://dmh.mo.gov/dd/hcbs.html>).
 - All newly enrolling HCBS providers go through an application and training process with DMH before enrolling with Medicaid and obtaining a contract with DMH.
 - DMH has incorporated the setting requirements into its provider application for HCBS providers. The application includes a section dedicated to educating providers on the HCBS rule and obtaining their commitment to comply with the rule. In addition, waiver providers of Group Home, Individualized Support Living, Shared Living, Day Habilitation, Community Integration, Individualized Skills Development, Employment and Personal Assistant services are evaluated based on responses to questions related to the HCBS rule. All HCBS providers are given information and the self-assessment.
 - DMH has incorporated the setting requirements into its newly enrolled HCBS provider pre-training assignment. Waiver providers of Group Home, Individualized Support Living, Shared Living, Day Habilitation, Community Integration, Individualized Skills Development, Employment and Personal Assistant services are required to complete this assignment prior to approval for enrollment with Medicaid and obtaining a contract with DMH.
 - DMH has incorporated the setting requirements into its Certification Instrument. Newly enrolling Waiver providers of Group Home, Individualized Support Living, Shared Living, Day Habilitation, Community Integration, Individualized Skills Development, and Employment services must obtain Certification or Accreditation prior to enrollment with Medicaid and obtaining a contract with DMH. Newly enrolling Waiver providers of

Personal Assistant must be DHSS providers or must obtain Certification or Accreditation prior to enrollment with Medicaid and obtaining a contract with DMH.

- **DHSS Waivers:**
 - MMAC posted information about the Final Rule and setting requirements on its website for all prospective and newly enrolling providers.
 - All newly enrolling HCBS providers go through a contract/proposal process with MMAC before receiving a MHD participation agreement.
 - MMAC personnel who handle the HCBS provider enrollment processes have received training regarding the Final Rule and setting requirements.
 - MMAC has incorporated the setting requirements into its proposal process for HCBS providers. Specifically, all HCBS providers are given information and the self-assessment. Adult Day Care and AIDS Waiver providers are surveyed by MMAC personnel during the pre-enrollment on-site visit.

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Section 2: Remediation Strategies

The State 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. The State 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.

Informational Letters

MHD required DMH and DHSS to draft informational letters describing the 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. This process began June 23, 2014 and will be completed by April 1, 2017. Information shared with stakeholders includes CMS Guidance, The Code of Federal Regulations, and the Proposed Transition Plan.

Missouri Code of State Regulation (CSR) Filing

The State will file changes to administrative rules as needed to reflect federal regulations on HCBS settings. The rulemaking process is lengthy, entailing a minimum of approximately nine months from the notice of rulemaking to a final rule. The State will begin filing changes to reflect the Home and Community Based Final Rule on March 1, 2015 and will complete the filing by January 1, 2017. The final file date will be dependent upon approval of the Governor's Office.

- **DMH Waivers:**
 - DMH determined that regulations did not contradict the HCBS rule and therefore no regulations were considered to be non-compliant.
 - DMH determined that regulations did contain partially compliant provisions concerning individual support plans; however the regulation did not include all components of the person-centered plan and process. DMH revised the regulation by including all the

language in the person-centered planning process and person-centered plan sections of the HCBS Rule. Certification of Provider regulations address individuals' needs for privacy, dignity, respect, choice of providers and services, but need to be amended to include requirements for freedom from coercion and restraint

- DMH determined that regulations contain compliant provisions concerning prioritizing access to services, utilization review process, and certification of providers. Sections in the rules include language that the planning process for service delivery is directed by the individual, includes preferences and outcomes desired by the individual, and requirements for community integration to ensure individuals are active in the community in which they live and work, self-determination, the assurance of rights, and the promotion of individual well-being.
- DMH determined that provider enrollment requirements were silent in state regulation, because there were no specific provider enrollment regulations. Provider Enrollment regulations were drafted and posted for public comment. These regulations include requirements that the provider must sign and agree to be in compliance with the HCBS Settings rule.

- **DHSS Waivers:**

- As a result of the assessment, DHSS found state standards compliant, partially compliant or non-compliant with the HCBS Rule. Adult Day Care Licensure 19 CSR 30-90, In-Home Service Standards 19 CSR 15-7, Personal Care Rule 13 CSR 70-91, Consumer Directed Services 19 CSR 15-8 will come into compliance upon the adoption and implementation of an overarching HCBS Waiver Administration rule that details the CMS HCBS settings characteristics required for all 1915c waiver settings. The State will add the new chapter to 13 CSR 70 entitled Home and Community Based Services (HCBS) Waivers. This rule implements federal regulatory requirements promulgated by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services at 42 CFR 441.301(c)(4) establishing the requirements that must be met for settings in which home and community based services are provided under a 1915(c) HCBS Waiver Program. A Public Comment period of 30 days will be held. Comments are submitted to the agency proposing the rule or rule changes. The agency will prepare a final order of rulemaking that includes summaries of all the comments received, the agency responds to each comment, and any changes made to the proposed rule as result of the comments. The final rule must be filed with the Secretary of State no later than ninety days from the date for filing public comment, or within ninety days after a hearing if a hearing is held on the proposed rulemaking. The new rule change becomes effective thirty days after the final order of rulemaking is published in the Code of State Regulations. Amendments needed to specific manuals are referenced in the remediation column of the crosswalk and language will be added upon CSR implementation.

Direct conflicts in the areas of individual initiative, respect and independence in making life choices, and freedom from coercion and restraint were identified in the Child and Adult Care Food Program manual, which affects participants receiving services through the Adult Day Care Waiver and Aged and Disabled Waiver, adult day care setting. These state guidelines are based directly on federal regulations (7 CFR 226.20) for the program. DHSS will continue to work with partners to address these inconsistencies.

Provider Manuals, Policies, and Procedures Revisions

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MHD, DMH, and DHSS will revise HCBS provider manuals, policies, and procedures to incorporate HCBS final rule requirements. The revisions will clarify expectations of participants' control of their environment and access to the community. Revisions to the provider manuals, policies, and procedures, including revisions to DMH waiver services definitions for Employment services, Day Habilitation, Community Integration, Personal Assistance, Individualized Skill Development to enhance and support integration in the community, began on January 1, 2015 and will be completed by July 1, 2017.

- DMH Waivers:
 - HCBS Definitions: Proposed changes were included in waiver renewal applications for the Comprehensive and Community Support Waivers. Amendments will be submitted to CMS for the remaining waivers. The following definition changes were submitted to help set expectations to appropriately align incentives toward individual integrated employment and community integration: Day Habilitation, Personal Assistance, Employment Services, Community Integration, and Individualized Skill Development
 - Guidelines, manuals, and contracts were partially compliant and are in the process of revision to incorporate all components of the HCBS settings rule. Contracts were revised to add a section that requires the contractor to ensure the delivery of waived services comports with the Federal Rule 42 CFR441.301 also referenced as the Home and Community-Based Services (HCBS) Waiver Rule.
- DHSS Waivers
 - DHSS Waiver program manuals and policies were either silent or partially compliant and are in the process of revision to incorporate all components of the HCBS settings rule. The Child and Adult Care Food Manual is in conflict with the HCBS settings rule and DHSS will continue to work with partners to address these inconsistencies.
 - Proposed changes for DHSS waivers will be included in each waiver renewal application.

Incorporate Education and HCBS Waiver Compliance Understanding into Provider Enrollment

MHD requires DMH, DHSS, and MMAC to educate providers on the HCBS Final rule, and to incorporate education into the Provider Enrollment process. Operating agencies will use resources and tools such as the Missouri Exploratory Questions for Assessment of HCBS Residential Waiver Settings, Missouri – Settings with the Potential Effect of Isolating Individuals from the Broader Community. The requirements of the Home and Community-Based Federal rule will be incorporated into Provider Enrollment Tools and the Provider Agreements. This process began on August 17, 2015 and will continue with all new providers enrolling on an on-going basis.

The State will evaluate through the heightened scrutiny process any new settings for enrollment that have an institutional or isolating quality while presenting deadlines for enrolled providers to come into compliance. Specific Department processes are outlined below.

- DMH Waivers
 - DMH will make adjustments to ensure that HCBS Waiver settings are evaluated when appropriate—Newly enrolling HCBS providers of Group Home, Individualized Support Living, Shared Living, Day Habilitation, Community Integration, Individualized Skills Development, Employment, Respite, and Personal Assistant services will be provided information on HCBS setting requirements through the application and training process prior to registering with Medicaid or contracting with DMH. DMH will require providers of Group Home, Individualized Support Living, Shared Living, Day Habilitation, Community Integration, Individualized Skills Development, Employment, Respite, and

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Personal Assistant services to certify that they have received, understand, and intend to 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.
- DHSS Waivers
 - MMAC has posted information regarding the Final Rule and setting requirements on its website for all prospective and newly enrolling providers.
 - Newly enrolling HCBS providers will be provided information on HCBS setting requirements as part of their enrollment materials.
 - MMAC personnel will educate all HCBS providers about the Final Rule and setting requirements during pre-enrollment on-site visits. Adult Day Care and AIDS Waiver Attendant Care providers will be surveyed during the pre-enrollment on-site visit.
 - MMAC will provide information to HCBS providers during Annual Provider Update Meetings held semiannually, Designated Manager Trainings held quarterly, and at other workshops, board meetings, seminars, and conferences.
 - MMAC will monitor and verify setting compliance for all Adult Day Care Providers and Doorways/Cooper House at each revalidation. Revalidation occurs at least every five years, and requires an on-site visit to the facility.
 - MMAC will monitor and verify setting compliance during on-site audits of Adult Day Care and AIDS Waiver Attendant Care providers. MMAC audits all HCBS providers every three years if not more often.
 - MMAC will monitor and verify setting compliance on an ad-hoc, more frequent basis when on-site for other reasons such as an investigation of the provider.

Provider Update Meetings and Trainings

MHD requires DMH and DHSS to educate providers on the HCBS Final rule during the Provider Enrollment process. Operating agencies will use resources and tools such as the Missouri Exploratory Questions for Assessment of HCBS Residential Waiver Settings, Missouri – Settings with the Potential Effect of Isolating Individuals from the Broader Community. This education began on June 23, 2014 and will continue ongoing thereafter. The requirements of the Home and Community-Based Federal rule will be incorporated into Provider Enrollment Tools and the Provider Agreements. Specific Department processes are outlined below.

- DMH Waivers
 - DMH will provide information regarding the HCBS settings rule and any further guidance from CMS to HCBS providers via webinars and during quarterly provider meetings in each region. Webinars will be posted on the DMH website and providers informed by email when webinars have been posted.
 - DMH will provide information and training to self-advocates, families, providers, stakeholders, etc. designed to enhance individualized person-centered planning.
 - DMH link to the periodic provider trainings :
<https://dmh.mo.gov/dd/docs/HCBSDraftTrainingCrosswalkSummaryupdatedJanuary2017.pdf>
- DHSS Waivers

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- MMAC will provide information to HCBS providers during Annual Provider Update Meetings and Provider Designated Manager Trainings, hosted by MMAC.
- MMAC will provide information to HCBS providers during MHD workshops.
- MMAC will provide information to HCBS providers during HCBS association meetings and conferences.

MHD recognizes that the two Operating Agencies of the State's ten HCBS waivers function in different manners. Therefore, MHD requested each agency to develop assessment and remediation processes unique to their structures and functions. The next section describes the processes by agency.

DMH Waivers:

HCBS Waiver Settings Initial Assessment Findings and Provider Individual Remediation

Upon completion of the initial assessments, DMH presented individuals, service providers and support coordinator entities with the results of the assessment within 45 calendar days of the initial on-site assessment. The initial on-site assessment summary of findings letter required HCBS Waiver service providers and support coordinator entities to submit a single collaborative remediation/transition plan within 45 calendar days from the date of the cover letter and findings report for any areas that required remediation to ensure compliance with the HCBS Settings Rule is achievable by March 2019. Providers and Support Coordinator entities will provide details about the steps to be taken to remediate issues and the expected timelines for compliance.

The remediation/transition plan must include the provider's plan with milestones to ensure compliance with the HCBS Final rule including systemic programmatic changes and assurances of documentation in the person-centered service plans. DMH requests providers to include in the submission amended or newly created policies, protocols, and procedures concerning the HCBS Setting Rule and to demonstrate how initial and ongoing compliance is ensured concerning the HCBS Settings Rule.

DMH review of remediation plans will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. DMH will review initial and ongoing compliance through providers' proposed system modifications and related changes to ensure compliance concerning the HCBS Setting Rule.

Provider remediation will occur from March 2, 2015 through March 17, 2018.

State Response to Provider Individual Remediation

DMH will accept the remediation/transition plan or may ask for changes to the plan. DMH may prescribe remediation requirements for each organization's HCBS Waiver settings. Changes may include evidence of changes to policies, procedures, manuals, and trainings.

Findings and Remediation Plans will be entered into a DMH tracking system and into the DMH Action Plan Tracking System (APTS) for individual specific remediation. The tracking systems are used by DMH staff to track findings and ensure final remediation in accordance with the HCBS Settings Final rule. APTS tracks findings and ensures final remediation in accordance with quality integrated functions in accordance with division directive 4.080 (<http://dmh.mo.gov/docs/dd/directives/4080.pdf>) and has been updated to include HCBS federal requirements.

If a provider does not meet the proposed milestones, this will be noted in the tracking system which could lead to placement on a provider improvement plan or a critical status plan (no growth/no

referral), or termination of contract as outlined in Division Directive 4.080. (<http://dmh.mo.gov/docs/dd/directives/4080.pdf>)

DMH will continue to work with providers to ensure compliance with the HCBS Settings rule between March 2, 2015 and March 17, 2018. Individuals in a non-compliant setting as of March 17, 2018 will begin the transition process to a compliant setting. Please see Individuals Transition to Settings that Align with HCBS Requirements section for further details.

Periodic Provider Remediation Status Updates

DMH will require all providers with remediation/transition plans to submit monitoring updates on a quarterly basis. The process for tracking and monitoring provider remediation plans will include monitoring provider transition plans by central office staff based upon milestones submitted and accepted by the department, during routine Provider Relations Reviews, Quality Enhancement Reviews to include National Core Indicator Surveys, TCM Technical Assistance Coordinator Reviews, Service Monitoring by Support Coordinators, and Licensure and Certification Reviews. A tracking spreadsheet that identifies the provider transition plan milestones and deliverable dates will be used to help coordinate this effort. The central office staff will monitor evidence submitted by the providers in relation to their approved milestones. Technical assistance will be provided if there is a problem with the implementation of the remediation plan, if providers are not implementing the plans or if the providers decide to significantly change their plans or the implementation of their plans. Status updates will occur between March 2, 2015 and March 17, 2018.

Assessment Results Report – State Level Remediation

After findings from settings assessments and provider and individual surveys have been presented to CMS, State leadership and stakeholders, the State will work with stakeholders to develop remediation strategies for any necessary systems process changes. Global systems enhancement might include revisions to existing integrated quality monitoring processes and enhanced HCBS provider and support coordination trainings. This process will occur between March 2, 2015 and March 17, 2018.

Ongoing Compliance/Monitoring Reviews

DMH will conduct ongoing reviews to establish and monitor levels of compliance. DMH will incorporate requirements of the HCBS Setting Rule into existing review processes and quality integrated functions: Provider Relations Reviews; Quality Enhancement Reviews including National Core Indicators; Targeted Case Management Technical Assistance Coordinator Reviews; Service Monitoring by Support Coordinators; Licensure and Certification Reviews; and the CIMOR EMT Contacts Process which includes anonymous input from individuals served and their advocates. The quarterly/annual monitoring processes include on-site, face to face assessments of providers with waiver participants.

- Provider Relations Reviews Guideline prescribes the functions of Provider Relations and incorporates monitoring for ongoing compliance of provider systems (<http://dmh.mo.gov/dd/guidelines.html>). This guideline has been updated to include monitoring compliance with the HCBS Settings Final rule. For example, it was updated to include a new component, “Lease HCBS,” which incorporates the lease requirements for provider-owned and controlled settings; and a new component, “Policies & Procedures support the HCBS Rule,” incorporates individual choice requirements in the HCBS Settings Final rule.
- Quality Enhancement Reviews to include NCI Surveys - The Quality of Services Review (QSR), which includes the National Core Indicator (NCI) survey as part of the review process and

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incorporates the Missouri Quality Outcomes, prescribes a standardized procedure to evaluate if individuals have full access to the benefits of community living and the opportunity to receive services in the most appropriate integrated setting, assess the person-centered planning process and provide feedback to the interdisciplinary team about utilizing key points of self-determination(Appendix B-Quality of Services Review Summary Word Document):

- Individuals will live a meaningful life in the community and be empowered in making life decisions.
- Individuals will have support to organize resources in ways that are life enhancing and assist them in reaching their dreams and goals. Individuals have a circle of supports made up of family, friends, and both paid and unpaid supports.
- Individuals assume responsibility for giving back to their community, for seeking employment, and for developing unique gifts and talents.
- Individuals are recognized for who they are and what they can contribute.
- Enhancing identified areas (values, choice, health, safety, inclusion, and self-advocacy).

- Individuals are able to choose health and mental health resources and are supported in making informed decisions regarding their health and well-being.
- Individuals are educated about their rights and practice strategies to promote their safety and security.
- Families are provided with knowledge that empowers them to facilitate opportunities for the individual's self-determination throughout the course of the individual's life.

The Quality of Services Review (QSR) is conducted with a statistically valid sample of individuals in the comprehensive waiver. Primarily, these individuals reside in residential settings but a marginal number of individuals reside in natural homes. Since this review process was implemented in FY16 and specifically based on the new HCBS rule, it is compliant with the quality required by regulation.

Reference:

- Guideline #54 Quality of Services Review (created 7/8/15 from Division Directive 3.100)PDF Document <http://dmh.mo.gov/dd/guidelines.html>
 - Appendix A-Quality of Services Review Supplemental Guide Word Document
 - Appendix B-Quality of Services Review Summary Word Document
- TCM Technical Assistance Coordinator Reviews is outlined in Guideline #9, Guidelines for Targeted Case Management Review. This guideline covers areas reviewed based on CMS assurances. The review tool was revised on July 1, 2015 to include person-centered planning requirements as required in the final HCBS rule. <http://dmh.mo.gov/dd/guidelines.html>
- Service Monitoring by Support Coordinators, Division Directive 3.020, was revised on September 23, 2015 to incorporate requirements in the final HCBS rule and was posted by April 2, 2016. The purpose of this directive is to prescribe the support monitoring standards. Support Coordinator training for the final HCBS rule and person centered planning guidelines occurred in January and July 2015. This was in advance of the revised ISP Guide which will incorporate requirements of HCBS rule based on stakeholder input and remediation.
- Licensure and Certification Reviews were evaluated and determined to be in partial compliance with the HCBS rule. The Survey Instrument used for the reviews includes all components of the

rule such as rights of privacy, dignity, respect, freedom for coercion, and individual choice. The instrument will be revised to include HCBS requirements regarding setting integration and individuals receiving services in the community.

- Review of ISP Guidelines: Individuals are provided information on rights upon entry to the waiver and annually during the individual support planning process. The support coordinator will provide a rights brochure, developed by the division, to the individual and guardian. In addition, information is posted on the division's web-site:
 - The DMH Consumer Rights brochure does not have specific language to comply with the final HCBS federal rule for anonymity. After reviewing the DMH Consumer Rights brochure, the Department will include the DMH website URL on the brochure and a statement in regards to the ability to make anonymous reports to Office of Constituent Services (OCS).
 - The Division Individual Rights document does not have specific language to comply with the final HCBS federal rule for anonymity. After reviewing the rights brochure developed by the division will include a statement in regards to the ability for individuals to make anonymous reports to OCS.
- Review of Missouri DMH-Office of Constituent Service website (<http://dmh.mo.gov/constituentservices/index.html>). The DMH Client Rights brochure and other information regarding consumer rights and abuse/neglect is posted on this web site. The site also has a consumer safety video 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. In the Frequently Asked Questions section on the website it does state and answer the question: ***What should I do if I suspect that a mental health client or family member may have been the victim of abuse or neglect?*** You may call the toll free number at 1-800-364-9687 and ask for the Office of Constituent Services. The office encourages everyone to make the contact for the safety of all clients. All calls will be kept confidential and the caller can choose to remain anonymous.
 - Review of Comprehensive Waiver Application states that the Division of DD Consolidated Contract requires that each provider give 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.
 - Review of the contract did not reflect this requirement. It is recommended that this statement be added to the contract to include the statement that an anonymous complaint can be made to the Office of Constituent Services.
- Review of the ISP Guide –The purpose of the ISP Guide is to ensure that the Person Centered Planning Process and resulting document meet the assessed needs of the individual and the regulatory requirements. In order to be compliant with the final HCBS rule the following requirements were added:
 - individual directs the person centered planning process;
 - individual understands methods for requesting changes;
 - plans are not written by direct service providers;

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- plans are written in plain language;
- plans include conflict resolution;
- plans include anonymous complaint information;
- plans include documentation of supports and setting options explored; and
- plan ensures needs are assessed, preferences are determined and risk factors minimized in the area of: Daily Life and Employment; Community Living; Social and Spirituality; Healthy Living; Safety & Security; Citizenship and Advocacy

The ISP Guide was also updated to ensure that all required documentation is included in the plan if there are any modifications to provider owned or controlled residential settings and those modifications are supported by a specific assessed need and justified in the ISP.

This milestone will begin April 2, 2015 and will continue on-going.

Provider Sanctions

In accordance with 13 CSR 70-3.030 and/or 9 CSR 45-5.060, DMH will sanction providers that have failed to meet remediation standards and have failed to cooperate with the HCBS Settings Transition. This milestone will begin February 3, 2015 and continue on an ongoing individual provider basis.

Individuals Transition to Settings that Align with HCBS Requirements

If relocation of individuals is necessary, the State will work with the individuals to ensure they are transitioned to settings meeting HCBS Setting requirements following Division Directive 5.010. The purpose of the directive is to implement a consistent, State-wide process for transfer of individuals, ensuring a smooth transfer that maintains services, with no delay in obtaining new supports and services. 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. The division is in the process of developing a Transition manual which will incorporate Division Directive 5.010 at which time the Division Directive will be rescinded. (<http://dmh.mo.gov/dd/directives/directives.html>). DMH estimates that less than 100 individuals will need to relocate.

This milestone will begin March 16, 2015 and continue on an individual provider basis.

DMH will utilize the Sanction Template Letter including the Notice of Decision (including appeal rights) and the Data warehouse query of members affected and corresponding support coordinators, service workers, and care coordinators.

DHSS Waivers:

HCBS Waiver Settings Assessment Findings and Provider Individual Remediation

MMAC posted aggregate initial on-site assessment results on the MMAC website (<http://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/>). DHSS will provide MMAC with the results of the participant surveys. MMAC will utilize those results by matching any participant surveys that identify the provider, with the provider surveys. MMAC will then conduct a second review to determine consistencies/inconsistencies and will prepare an addendum to the report, which will be posted to the website, as well.

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MMAC will present providers with results via US Mail, including a self-addressed, postage-paid envelope. MMAC will request providers submit feedback to the results, including individual transition plans that address any area(s) of noncompliance. These results or “summary of findings” (including requests for individual transition plans) will be distributed to service providers by August 1, 2016. These plans will provide details about the steps to be taken to remediate issues and the expected timelines for compliance. This timeline, with milestones, will ensure providers have ample time to reach compliance. MMAC personnel will provide assistance to any provider that requests it, regarding how to achieve compliance.

The review of individual transition plans will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. MMAC will allow reasonable timeframes for large infrastructure changes. MMAC will track responses with dedicated follow up on a semi-annual basis. This will be done for 100% of Adult Day Care providers and AIDS Waiver Attendant Care providers.

Providers that become compliant are still subject to a review to verify their compliance. Providers that do not appear to have become compliant, or when there is reason to believe they are not compliant are subject to a review and will also be notified of future consequences (provider sanctions).

If a provider fails to become compliant, sanctions may be imposed according to 13 CSR 70-3.030.

MMAC Response to Provider Individual Transition Plans

MMAC will receive the individual transition plans. MMAC personnel will track receipt of the plans, conduct an initial review, and continue to review in a semi-annual fashion.

MMAC will provide feedback to providers after the initial reviews and after subsequent reviews. Subsequent reviews will be completed as providers achieve milestones, after they submit updates or changes to their transition plans, and every six months as part of MMAC’s semiannual review.

MMAC’s feedback will inform providers if it appears (a) they have become wholly compliant; (b) if they are making progress toward compliance; or (c) if it appears they are not making progress toward compliance. MMAC will give the providers details regarding what steps they must take to achieve compliance and provide assistance if requested. Progress toward compliance will be indicated by the individual transition plans sufficiency and by the providers making actual changes based upon their plans.

As MMAC audits all HCBS providers every three years, all providers who submit individual transition plans are subject to a review, regardless of whether or not they appear to be compliant, making progress toward compliance, or if they appear to be non-compliant. Compliance to the Final Rule and setting requirements will be incorporated into MMAC’s audit tool. Therefore, MMAC will review the providers’ adherence to their plans by the level necessitated by the scope of apparent noncompliance. MMAC may visit the provider solely for the purpose of plan adherence, may conduct an audit, or may open an investigation.

Providers that do not become compliant, or when there is reason to believe they are not compliant, will be notified of provider sanctions according to 13 CSR 70-3.030.

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MMAC's response to individual provider transition plans will occur between March 2, 2015 and March 17, 2018.

Periodic Provider Remediation Status Updates

Providers will submit semiannual status updates based on each aspect of the individual transition plans. MMAC will follow a process of semiannual review. Technical assistance will be provided if there is a problem with the implementation of the individual transition plans, such as providers failing to properly implement the plans, providers changing the plans, or changing implementation strategies. Status updates will occur between March 2, 2015 and March 17, 2018.

Assessment Results Report – State Level Remediation

After findings from settings assessments and provider and individual surveys have been presented to CMS, State leadership and stakeholders, the State will work with stakeholders to develop remediation strategies for any necessary systems processes changes. This process will occur between March 2, 2015 and March 17, 2018.

Ongoing Compliance/Monitoring Reviews

MMAC will conduct ongoing reviews of enrolled Adult Day Care and AIDS Waiver Attendant Care providers to establish and monitor levels of compliance. MMAC will incorporate settings requirement information into its pre-enrollment and revalidation site visits of all HCBS providers, and survey the Adult Day Care and AIDS Waiver Attendant Care providers during these visits. MMAC will also provide information about the setting requirements during on-site audits and investigations of HCBS providers.

Ongoing reviews include the following:

- On-site surveys completed during provider revalidation, to occur no less than every five years.
- On-site surveys completed during provider audits, which occur every three years.
- Provider assessments will be used as a training tool during Annual Provider Update Training. This training is held twice a year, and providers attend either the spring session or the fall session
- Provider assessments will be used as a training tool at annual provider association conferences
- MMAC personnel will perform reviews of individual provider transition plans. These reviews will be completed upon receipt, and in a dedicated fashion semiannually. The reviews may be completed more often in cases of provider milestones, or plan changes.
- Ongoing assessment will also occur on an ad hoc basis due to provider investigations, meetings, formal requests for education, and informal communications.
- Reviews may also be conducted when there is reason to believe a provider previously found to be non-compliant has not improved.
- When providers previously found to be non-compliant have improved, spot-checks may still be conducted outside of scheduled audits, investigations, or revalidation efforts, solely for the purpose of checking ongoing compliance levels.

DHSS will continue to reassess HCBS participants, including those receiving the Adult Day Care service and AIDS Waiver Attendant Care services. All participants authorized for HCBS shall have a reassessment completed within 365 days of the last level of care determination. For participants receiving an Adult Day Care service, DHSS or its designee shall perform face-to-face reassessments with the participant utilizing the InterRAI HC and the HCBS Care Plan and Participant Choice Statement (DA-3) to establish continued eligibility of services and compliance with the HCBS Settings Rule. For AIDS Waiver participants, DHSS will administer an annual participant survey and case management staff will

perform face-to-face reassessments with participants and include review of compliance with the HCBS Settings rule. Any concerns with specific settings shall be reported to MMAC.

The process began on April 2, 2016 and will continue on an on-going basis.

Provider Sanctions

In accordance with 19 CSR 30-90, MMAC will sanction providers that have failed to meet remediation standards and have failed to cooperate with the HCBS Settings Transition.

Individuals Transition to Settings that Align with HCBS Requirements

If relocation of individuals is necessary, the local DHSS Adult Protective and Community staff will work with individuals through phone contact and face-to-face visits to ensure they are transitioned to settings meeting HCBS Setting requirements. Individuals will be given timely notice, 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. DHSS estimates less than 450 participants may need to be relocated to HCBS compliant settings.

This milestone will begin March 16, 2015 and continue ongoing on an individual provider basis.

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Section 3: Public Comment

The State proposed to collect public comments on the transition plan in-person during two public forums. The State also offered a conference line during the public forums and provided an address for the public to mail in comments. The State received comments from stakeholders through a series of stakeholder forums conducted throughout the state. In addition to posting the transition plan and related materials on the 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. The State and the DD Council will continue to explore opportunities to ensure that individuals and families receive and understand information regarding the HCBS rule, and that they are a part of system changes.

Additionally, for DHSS waivers, the Missouri Adult Day Care Association and Leading Age Missouri were contacted.

Announcement of Public Comment Period

The State released a Summary document, the Draft Transition Plan, and Draft Settings Analysis on the state website. A newspaper notice and an email blast were released on December 30, 2014, and the stakeholders were contacted directly to inform them of the opportunity to provide public comment. This began on December 29, 2014 and was completed on March 7, 2015. The notice included the draft transition plan, the draft settings analysis, and the HCBS Settings Summary Document.

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Public Comment Period and Meetings - Proposed Transition Plan

The State commenced stakeholder forums, shared the proposed transition plan with the public, collected comments, developed state responses to public comments, and incorporated appropriate suggestions into the 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. This began on December 29, 2014 and was completed on March 7, 2015.

Announcement of Public Comment Period – Amended Transition Plan

The State released the Draft Amended Statewide Transition Plan on the state website. A newspaper announcement and an email blast were released and stakeholders were contacted directly to inform them of the opportunity to provide public comment. This began on July 29, 2016 and was completed on September 30, 2016.

Public Comment Period and Meetings - Amended Transition Plan

This amended Statewide Transition Plan builds on the originally proposed Statewide Transition Plan submitted on March 14, 2015. This plan includes data gathered from the provider and participant self-assessments, information submitted in response to the CMS Letter of Reaction, as well as further details in response to conference calls held with CMS on September 15, 2015 and March 17, 2016 regarding settings and assessment validation. This Amended Transition Plan also reflects guidance that continues to be issued by CMS, including but not limited to the Settings Requirements Compliance Toolkit and the HCBS Training Series Webinars Presented During SOTA Calls (Home and Community-Based Settings, Excluded Settings, and the Heightened Scrutiny Process – November, 2015; and Home and Community-Based Setting Requirements: Systemic and Site-Specific Assessments and Remediation – December, 2015).

The State commenced stakeholder forums, shared the proposed transition plan with public, collected comments, developed state responses to public comments, and incorporated appropriate suggestions into the 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. This began on July 29, 2016 and was completed on September 30, 2016.

Public Comment Retention

The State will safely store public comments and state responses for CMS and public consumption. This began on December 29, 2014 and will be completed on March 17, 2019.

Posting of Transition Plan Iterations

The State will post each approved iteration of the transition plan to its website. This began on December 29, 2014 and will be completed on March 17, 2019.

The state will include the Transition Plan and the rationale for the changes made.

Assessment Findings Report

The State posts the summary of findings of the initial on-site assessments and remediation strategies annually by August 1. This will begin on July 1, 2016 and will be completed on January 1, 2017. The State will include the data compiled and the remediation strategies at an aggregate level.