

STATE OF MISSOURI



DEVELOPMENTAL
DISABILITIES WAIVERS
MANUAL



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Developmental Disabilities Waivers Manual Comprehensive, Support, Autism, MOCDD (otherwise known as the Sara Jian “Lopez” Waiver), and Partnership for Hope Waiver Manual

Introduction to Medicaid Waivers in Missouri

The Missouri Department of Mental Health's Division of Developmental Disabilities (Division of DD) administers five Medicaid Home and Community-Based Services (HCBS) Waiver programs for individuals with developmental disabilities. The five waivers are the Comprehensive Waiver; Missouri Children with Developmental Disabilities Waiver (MOCDD or Lopez Waiver); Support Waiver; Partnership for Hope Waiver (PfH); and Autism Waiver.

Authority for the Division of DD waivers is the result of a federal law enacted by Congress in 1981 that added a new section to the Social Security Act in 1915(c). Under home and community-based waivers, a state may use Medicaid funding for home and community-based services provided only to a target group of people who have intellectual and developmental disabilities and whose care needs would otherwise require services in an institution. Federal law also allows a state to target services by geographic region. The Division of DD uses general revenue funds and local county dollars to match federal dollars to pay for HCB waiver services.

Section A: Eligibility and Planning

Eligibility

An individual must meet the following eligibility requirements to be eligible for any waiver services that the state of Missouri operates.

The Intermediate Care Facility/Intellectual and Development Disabilities (ICF/IDD) level of care requires the presence of developmental disabilities as defined in federal rule (42 CFR 435.1010) as:

Persons with related condition as follows: Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:

- (a) It is attributed to—
 - (1) Cerebral palsy or epilepsy; or
 - (2) Any other condition, other than mental illness, found to be closely related to developmental disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services similar to those required for these persons;
- (b) It is manifested before the person reaches age 22;
- (c) It is likely to continue indefinitely;
- (d) It results in substantial functional limitations in three or more of the following areas of major life activity:
 - (1) Self-care;
 - (2) Understanding and use of language;



- (3) Learning;
- (4) Mobility;
- (5) Self-direction;
- (6) Capacity for independent living, plus a need for the level of care provided in an ICF/IDD.

In addition, a determination must be made that the individual is at risk of needing ICF/IDD institutional services if unable to access waiver services. To access waiver services, Medicaid eligible applicants must first be determined eligible for services by the Division of DD regional office through an assessment process. The assessment includes the Missouri Critical Adaptive Behavior Inventory (MOCABI) for adults or the Vineland or other age appropriate instrument(s) for children. Observations, interviews and collateral information are also used. Once eligibility for Division of DD services is determined, a support coordinator uses the gathered information and any other information needed to evaluate the applicant's eligibility for the Division of DD waiver program.

In addition to the criteria listed above each waiver has particular eligibility criterion that must be met to participate in the specific waiver as noted below.

SERVICE LIMITATIONS

- The person *must* be eligible for Medicaid in an allowable eligibility category when the services are delivered.
- Medicaid does *not* cover services for individuals residing in a jail or detention facility.
- Medicaid waiver services are *not* available to individuals who are inpatients in a nursing home, ICF/IDD or a hospital.

Special Documentation Requirements

The documents discussed in this section are required for Division of DD Waiver services compliance.

Evaluation of Need for ICF/IDD Level of Care and Eligibility for the Developmental Disabilities Waivers

Before a person enters the Developmental Disabilities waivers, a support coordinator employed by a Division of DD regional office, or other approved targeted case management (TCM) entity that contracts with Division of DD to provide TCM services, gathers collateral information and assures that social history and medical information is current. The support coordinator also ensures that results of any testing or previous habilitative program experience are summarized, and that any additional professional assessment necessary for determining level of care or individual planning is requested. The support coordinator then completes a functional screening instrument designed to provide general information on what a person with developmental disabilities can and cannot do and lists any types of adaptations and supports which are in use.



The MOCABI is the instrument used for adults and for older children, when appropriate. Other age appropriate instruments, such as the Vineland, may be used for younger children. Based on the MOCABI, Vineland or other appropriate instrument, and on observation, interviews, collateral information and assessments, the support coordinator documents on the Evaluation of Need for ICF/IDD Level of Care Form:

- That the individual has developmental disabilities and/or a disability that meets the federal definition of a “related condition;”
- That the individual has limitations, which if not for home and community-based waiver services, may require active treatment in an ICF/IDD; and
- Why the individual is at risk of entering an ICF/IDD;
- Based on the results documented on this form, the individual may be determined eligible for waiver services;
- Only support coordinators employed by a regional office, other approved TCM entities contracting with Division of DD, have authority to evaluate ICF/IDD level of care for the Developmental Disabilities Waivers. All level of care evaluations must be administratively approved through a regional office.

Re-evaluation of Level of Care

Support coordinators associated with the TCM entities described above shall re-evaluate each individual at least every 365 days for continued eligibility for Developmental Disabilities waivers, which includes continued need for an ICF/IDD level of care. The re-evaluation includes the reviewing and/or updating all assessments on which the previous evaluation was based, including the MOCABI, and re-documentation of conditions of eligibility as listed above. Ensuring the re-evaluation is done at least every 365 days and maintaining copies of the initial evaluation, all assessments and subsequent reevaluations, is the responsibility of the DD TCM entity.

Functional Assessment and Individual Support (also called Service) Plan

No later than 30 days from the date of eligibility for DD services, the individual and his or her planning team develops an Individual Support Plan (ISP), also known as the support plan. The person-centered planning process is implemented to develop the ISP, facilitated by the support coordinator.

As required by 42 CFR 441.301 (c) (1), the person-centered planning process will be led by the individual where possible. In addition to being led by the individual receiving services and supports, the person-centered planning process:

- Includes people chosen by the individual;
- Provides adequate information and support to ensure the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Is timely and occurs at times and locations of convenience to the individual;
- Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who has limited English proficiency;
- Includes strategies for solving conflict or disagreement within the process including clear conflict of interest guidelines for all planning participants;



- Offers informed choices about the services and supports they receive and who provides them;
- Includes a method for the individual to request updates to the plan when needed; and
- Records the alternative HCBS settings that were considered by the individual.

Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop ISPs in a geographic area also provides HCBS.

The ISP is in accordance with 42 CFR 441.301 (c) (2) and (3). The ISP is based on functional assessment, which includes all other assessments that are pertinent, and the observations and information gathered including members of the interdisciplinary team. The ISP must:

- Reflect the setting in which the individual resides is chosen by the individual; and the setting must be integrated in and support full access to the greater community including; employment opportunities to work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
- Reflect the individual's strengths and preferences;
- Reflect clinical and support needs as identified through assessment of functional need;
- Include individually identified goals and desired outcomes;
- Reflect services and supports (both paid and unpaid) that will help the individual achieve identified goals, and the providers of those services and supports, including natural supports;
- Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed;
- Be understandable to the individual receiving services and supports, and individuals who are important in supporting the individual. The ISP shall be in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed with informed consent of the individual in writing; signed by all individuals and providers responsible for its implementation;
- Be distributed to the individual and other people involved in the plan;
- Include those services, the purpose or control of which the individual elects to self-direct;
- Prevent the provision of unnecessary or inappropriate services or supports; and
- Document that any modification of the additional conditions, under paragraph 42 CFR 441.301 (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the ISP. The following requirements must be documented in the ISP:



- Identify a specific and individualized assessed need;
- Document positive interventions and supports used prior to any plan modification;
- Document less intrusive method of meeting the need that were tried but did not work;
- Include a clear description of the condition that is directly proportionate to the assessed need;
- Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
- Include informed consent of the individual;
- Include an assurance that interventions and supports will cause no harm to the individual; and
- The ISP must be reviewed, and revised upon reassessment of functional need at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

The ISP describes how the individual chooses to live his or her life, and how he or she wants to learn. The ISP must reflect the full range of an individual's service needs and include both the waiver and non-waiver services and supports needed to address those needs, and identify the type of provider(s) of those supports. The ISP must contain, at a minimum: the services that are furnished, the amount and frequency of each service, and the type of provider to furnish each service. Providing supports or making adaptations to the environment may be part of the ISP. The ISP also specifies any possible limitations/challenges the planning team may foresee (and how these limitations may be overcome) to support the person to achieve the individual's desired outcomes. Such limitations may be related to such areas as financial and/or health and safety.

If the individual already has an ISP, the planning team updates that plan. The ISP must be revised as necessary to add or delete services or modify the amount and frequency of services. ISP changes may be necessary due to a change in the individual's needs. Services provided prior to the approval of the ISP and services not included in the ISP cannot be funded through the waiver.

The planning team includes the individual and his or her representative(s), family or guardian. The individual chooses whom he or she wants to attend as a member of the team, unless the individual is a minor or has been judged incompetent, in which case the family or guardian must attend. The team also includes a support coordinator and providers selected by the individual. Other professionals involved with the individual may be included as applicable and at the individual's or their representative's invitation. The ISP shall be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation, per 42 CFR 441.301(c)(2)(ix). This includes, but is not limited to: the support coordinator, the individual and/or his or her representative. Every attempt is made to obtain written approval and all attempts are documented in the individual's file. All members of the planning team



are provided a copy of the completed plan as appropriate. The division approves the ISP Budget and services justification in the ISP. The effective date of the ISP is determined, and shall be no earlier than the date of the planning meeting.

Service providers are selected by the individual or his or her family or guardian. The provider shall provide services in support of each individual's ISP based on a person-centered planning process and approved by the regional office. The provider shall be given a service authorization specifying the amount, duration, scope and frequency of services in the ISP for which they are responsible. Per 42 CFR 441.301(c)(2)(x), the signed and completed ISP must be distributed to the individual and other people involved in the plan and are responsible for its implementation.

Prior Authorization

Before delivering any Developmental Disabilities waiver service, the provider must receive prior authorization approval from the DD regional office. The Division of DD has an automated prior authorization and billing system. The DD Waiver service provider can use a compatible personal computer and modem to link to the regional office billing system. Once linked, the provider is able to view a screen that authorizes the specific service, rate and quantity the provider is approved to deliver for a specific period for each individual that they have been approved by the regional office to serve. Waiver providers are given access to the automated system and instructions on its use by the regional office.

Service Authorization

The Service Authorization is an automated document derived from and supported by the ISP. Division of DD regional offices use an automated system that allows support coordinators to request services identified through the ISP. The regional offices approve the services on-line. A computer printout of the service authorization can be generated by the regional office as needed. The automated system that creates the service authorization has edits to ensure data integrity such as correct dates and mathematical calculations.

The service authorization, which is subject to federal, MO HealthNet Program Operations, Missouri Medicaid Audit and Compliance Unit (MMAC), and Department of Mental Health (DMH) audit, specifies the following:

- Units of service;
- Period of service;
- Provider of each service;
- Total cost of the plan; and
- Approval by the regional offices.

Home and Community-Based Services (HCBS) Settings Requirements

In accordance with 42 CFR 441.301(c)(4), the setting must ensure that individuals receiving services and supports through the Medicaid HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting. Participants must have choices in where they live, where they work, and how they do things in the community.



Medicaid Waiver, Provider, and Services Choice Statement

When it is determined that a person needs the level of care provided in an ICF/IDD, the support coordinator informs the person and, if applicable, a legal guardian of any feasible alternatives available under the waiver and gives the person the choice of either institutional or HCBS waiver services. Some people with developmental disabilities may qualify for more than one waiver; however, a person can only receive services in one waiver at a time. If the individual or legal guardian chooses to participate in the waiver, a Medicaid Waiver, Provider, and Services Choice Statement must be signed prior to entry into Developmental Disabilities waiver services. Ensuring the choice statement is completed and the document is maintained is the responsibility of the entity that is providing support coordination.

This choice form also provides, for applicable services, the option for the individual to self-direct all or some of their Developmental Disabilities waiver services.

When more than one provider of service is enrolled as a Developmental Disabilities waiver provider for a particular geographic area, the individual and legal guardian must be given a choice among those providers. The Medicaid Waiver, Provider, and Services Choice Statement are used for this purpose. Choice among providers may be limited only if a person's needs are so highly specialized that only an equally highly specialized provider can meet those needs. The limitation must be noted in the individual's record. The entity that is providing support coordination is responsible for ensuring Medicaid Waiver, Provider, and Services Choice Statement are obtained and are maintained in the individual's case record.

Individual Rights to Due Process

Medicaid rights of due process are extended to persons who participate in the Developmental Disabilities waivers. Individuals have the right to appeal anytime adverse decisions are made or actions are taken. Some examples of adverse action that may be appealed include situations where the individual:

- Is denied participation in the waiver;
- Requests a waiver service but authorization is denied;
- Is determined no longer eligible for the waiver; or
- Has services or units of service reduced without written approval of the individual or guardian.

When adverse action is necessary such as termination, reduction, or suspension of waiver services, etc., the support coordinator whether employed by the Division of DD regional office or TCM entity is responsible for notifying the individual in writing at least 10 days prior to any action being taken. Individuals have appeal rights through the Department of Mental Health and Department of Social Services (DSS), MO HealthNet Division. While not required to do so, individuals are encouraged to begin with the Department of Mental Health's appeal process. The Department of Mental Health appeal system shall not be a substitute for the DSS State fair hearing process. The DSS shall maintain an independent State fair hearing process as required by Federal law and regulation. The individual may appeal to the MO HealthNet Division, before, during and after exhausting the Department of Mental Health process. Once the individual begins the appeal process with the DSS, all



appeal rights with the Department of Mental Health end since any decision by the single State Medicaid Agency would supersede a decision by Department of Mental Health.

The individual is informed of the appeal process in the written notice. If the adverse action concerns termination or reduction of ongoing waiver services, the individual may request the disputed service(s) be continued until the hearing is held and a decision is made on the appeal. If such continuation is requested, and if the result of the agency's decision is upheld, the individual may be required to pay for the continued services. If the agency's decision is overturned, the individual is not responsible for the cost of services. Copies of written notices of adverse action and requests for a Fair Hearing are kept in the individual's record maintained by the regional office or TCM entity.

To appeal through the DSS MO HealthNet Division when a waiver service is denied, reduced or terminated, contact the MO HealthNet Participant Services Unit at 1-800-392-2161 or 573/751-6527. Individuals have 90 days from the date of the letter which denies, reduces or terminates a service to ask for a hearing.

Individuals are provided information on rights upon entry to the waiver and annually during the person centered planning process. The Division has a brochure individuals are given by support coordinators. In addition, information is posted on the Division's web-site.

Comprehensive Waiver

To be eligible for the Comprehensive Waiver an individual must:

- Be eligible for Medicaid (otherwise known as MO HealthNet) as determined by Family Support Division (FSD) under an eligibility category that provides for Federal Financial Participation (FFP);
- Be determined by regional office to have a developmental disability as defined by Section 630.00-5(9), RSMo, (1994); and
- Be determined by the regional office initially and annually thereafter to require an ICF/IDD level of care.

Support Waiver

To be eligible for the Support Waiver an individual must:

- Be eligible for Medicaid (otherwise known as Mo HealthNet) as determined by FSD under an eligibility category that provides for Federal Financial Participation (FFP);
- Be determined by regional office to have a developmental disability as defined by Section 630.005(9), RSMo, (1994);
- Be determined by the regional office initially and annually thereafter to require an ICF/IDD level of care;
- Have needs that can be met within the waiver cap of \$28,000 (this amount is adjusted annually by the consumer price index).

Missouri Children with Developmental Disabilities (MOCDD or Sarah Jian Lopez) Waiver

In order to be considered for participation in the MOCDD Waiver, the child must:



- Be eligible to receive Division of DD services (have a developmental disability as defined by Section 630.005(9), RSMo, (1994));
- Be living at home;
- Be under the age of 18; and
- Have a need for a waiver service;
- Not be eligible for any regular MO HealthNet programs;
- Require an ICF/IDD level of care and be at risk of entering an ICF/IDD facility if not provided services under the waiver.
- Be determined by the regional office initially and annually thereafter to require an ICF/IDD level of care.

It must also be determined:

- That maintaining the child at home rather than in placement, is both safe and economical (cost less than the equivalent level of care in an ICF/IDD).
- If other agencies (First Steps, local school districts) are serving or have primary responsibility for providing formal paid supports to the child; or
- If the child is eligible for other state plan MO HealthNet services (such as those provided under the Bureau of Special Health Care Needs (BSHCN) that would meet the child's needs). If these services do not meet the child's needs (provide an adequate level of services and/or the appropriate type of services), then waiver services may be considered.

Autism Waiver

For an individual to be eligible for the Autism Waiver the individual must:

- Be eligible for Medicaid (otherwise known as Mo HealthNet) as determined by FSD under an eligibility category that provides for Federal Financial Participation (FFP);
- 3 through 18 years of age;
- Live with his/her family in the community;
- Have a diagnosis of Autism Spectrum Disorder (ASD) as defined in the Diagnostic and Statistics Manual of Mental Disorders, American Psychiatric Association. The diagnosis must be made by a qualified professional using an approved screening/diagnostic tool which include, but are not limited to:
 - CARS – Childhood Autism Rating Scale,
 - GARS – Gilliam Autism Rating Scale,
 - M-CHAT – Modified Checklist for Autism in Toddlers,
 - PDDST-II – Pervasive Developmental Disorders Screening Test, Second Edition,
 - ADOS – Autism Diagnostic Observation Scale Interview, Revised Generic and Autism Diagnostic Interview, Revised,
 - ADI – Autism Diagnostic Interview, Revised, or
 - ASDS – Asperger Syndrome Diagnostic Scale.
- The child must have behavioral and/or social, or communication deficits that require supervision, that impact the ability of the child's family providing care in the home, and that interfere with the child participating in activities in the community;
- Be determined by the regional office initially and annually thereafter to require an ICF/IDD level of care;



- Have needs that can be met within the waiver cap of \$22,000.

Partnership for Hope Waiver

To be eligible for the PfH Waiver individuals must:

- Be a resident of a participating county upon enrollment and while receiving waiver services;
- Be eligible for Medicaid (otherwise known as MO HealthNet) as determined by FSD under an eligibility category that provides for Federal Financial Participation (FFP);
- Be determined by regional office to have a developmental disability as defined by Section 630.00 5(9), RSMo, (1994);
- Persons do not require residential services and typically are living in the community with family members;
- The individual is at risk of needing ICF/IDD institutional services if unable to access waiver services to subsidize care and support provided by the community and/or family;
- The estimated cost of waiver services and supports necessary to support the person must not exceed \$12,000 annually.
- Be determined by the regional office initially and annually thereafter to require an ICF/IDD level of care.

Prioritization of Need

Access to waivers is based on prioritization of need (PON). The Comprehensive, Support, Autism and MOCDD (Lopez) waivers use an assessment instrument that assigns a score between 0 and 12 for each waiver applicant, with 12 indicating the highest priority of need. The PON process is described in 9 CSR 45-2.017.

Access to Partnership for Hope is based on two categories: “Crisis” and “Priority”. Applicants who meet “Crisis” criteria will be served first. If multiple people in the same county meet “Crisis” criteria, the person who has been waiting the longest will be served first. If no one is in the “Crisis” category then the applicant who meets “Priority” criteria, who has been waiting the longest, may be served. The SB 40 Board determines the category for each applicant. Following is the criteria for the two categories:

Crisis

Each bullet point in Priority Category has equal weight.

- Health and safety conditions pose a serious risk of immediate harm or death to the individual or others;
- Loss of Primary Caregiver support or change in caregiver’s status to the extent the caregiver cannot meet needs of the individual; or
- Abuse, Neglect or Exploitation of the individual.

Priority

Each bullet point in Priority Category has equal weight.

- Individual’s circumstances or conditions necessitate substantial accommodation that cannot be reasonably provided by the individual’s primary caregiver;



- Person has exhausted both educational and Vocational Rehabilitation (VR) benefits or is not eligible for VR benefits and has a need for pre-employment or employment services;
- Individual has been receiving supports from local funding for three months or more and services are still needed and the service can be covered by the waiver; or
- Person living in a non-Medicaid funded Residential Care Facility (RCF) chooses to transition to the community and determined capable of residing in a less restrictive environment with access to the PfH Waiver.

Exceptions Processes for Division of DD Waivers

Waiver Cost Cap

If an individual has a change in condition or circumstances that exceed the cost limit, to ensure health and welfare of the individual an exception may be granted, on a case-by-case basis, for additional services above the individual cost cap. The exceptions process must be documented and maintained by the regional office.

- The Autism Waiver has an annual individual cost cap of \$22,000;
- The Support Waiver has an annual cost cap of \$28,000, which is adjusted annually by the consumer price index; and
- The PfH Waiver has an annual individual cost cap of \$12,000. If an individual has needs in excess of the cost limit, to ensure health and welfare of the individual an exception may be granted for additional services above the individual cost cap. An exception may be granted to exceed the annual individual cost cap for a one-time expense or during a crisis or transition period in an amount not to exceed \$10,000. An exception may be granted to exceed the individual cost cap for an ongoing excess amount of up to \$3,000 annually.

The support coordinator will revise the ISP to add information regarding the increased need.

For exceptions, whether it be waiver cost cap or service cost cap the ISP will go to Utilization Review (UR) for approval or denial. Exceptions are granted by the Division Director or designee (Regional Director) utilizing the Exceptions Form. A copy of the completed Exceptions Form and the amended ISP must be retained by the TCM entity and the regional office.

PfH waiver exceptions are requested when the support coordinator revises the ISP, after consultation with the individual and the planning team. The request for the exception is mutually approved by the County Board Director, Regional Director and DD Deputy/Assistant Director.



Section B: Degreed Professional Management Definition

Degreed Professional Management

A supervisory and management function required in certain DD waiver services.

Relevant experience may be substituted for Bachelor's degree. The provider is responsible for maintaining documentation of the credentials of the professional manager.

Responsibilities include:

- Staff training and supervision;
- Quality enhancement monitoring;
- Direct plan implementation for individuals as needed;
- Monitoring implementation of outcomes;
- Establishing information collection systems;
- Writing monthly reviews;
- Oversight/coordination of all the person's programs and services being received; and
- Coordinating the development of the ISP (scheduling, facilitation and summary document).

Developmental Disability Professional (formerly known as QDDP) is NO LONGER required for the following services: Community Employment, Independent Living Skills Development, Group Home, Individual Supported Living (ISL), Out of Home Respite, and Personal Assistance. The management functions for these services may be carried out by a professional manager, who either has a bachelor's degree or relevant experience.

Section C: Documentation Requirements

Adequate Documentation

All services provided must be adequately documented in the individual record. Per 13 CSR 70-3.030(2)(A) definition Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

“Adequate medical records” are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the individual to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered, with the exception of in-home services such as personal care, home health, etc.

Documentation

Implementation of services as authorized must be documented by the provider and is monitored by the support coordinator at least monthly for individuals who receive group home or individualized support living (ISL) and at least quarterly for individuals who live in their natural home.



As per 13 CSR 70 – 3.030 (Link: www.sos.mo.gov/adrules/csr/current/13csr/13csr.asp), the provider is required to document the provision of Division of DD Waiver services by maintaining:

- First name, last name, and either middle initial or date of birth of the service individual;
- An accurate, complete, and legible description of each service(s) provided. This information may be included in daily activity records that describe various covered activities (services) in which the individual participated;
- Name, title, and signature of the Missouri Medicaid (otherwise known as MO HealthNet) enrolled provider delivering the service. This may be included in attendance or census records documenting days of service, signed by the provider or designated staff; records indicating which staff provided each unit of service; and documentation of qualifications of staff to provide the service;
- Identify referring entity, when applicable;
- The date of service (month/day/year). This can be included in attendance or census records;
- Start and stop time must be included in the documentation for MO Health Net programs and services that are reimbursed according to the amount of time spent in delivering the service, such as personal assistant. (e.g., 4:00 – 4:30 p.m.);
- Services that do not have a time factor in completing the service does not require a start and stop time, but would need to have related documentation to verify the service was provided (e.g., invoices for equipment, trip reports for transportation, etc);
- The setting in which service was rendered;
- ISP, evaluation(s), test(s), findings, results, and prescription(s) as necessary;
- Service delivery as identified in the ISP;
- Individual's progress toward the goals stated in the ISP (progress notes). Sources of documentation include progress notes by direct care staff regarding situations (whether good or bad) that arise affecting the individual; and monthly provider summaries noting progress on individual's goals and objectives in their ISP, and overall status of the individual;
- For applicable programs, include invoices, trip tickets/reports, activity log sheets, employee records (excluding health records), and staff training records;
- Applicable documentation should be contained and available in the entirety of the medical record.

All providers must follow the above documentation requirements unless otherwise noted in Section F of this manual.

Section D: Self Directed Supports

Self-Directed Supports (SDS) is an option for individuals who live in a private residence. SDS enables individuals with developmental disabilities to exercise more choice, control and authority over their supports. SDS is founded on the principles of Self-Determination. Under this option the individual or his/her designated representative has employment and budget authority.



- Employment authority allows the individual or his/her designated representative to recruit, hire, train, manage, supervise and fire employees;
- Budget Authority allows the individual or his/her designated representative flexibility over managing a yearly budget allocation. For example, they may utilize more services in one month and less in another, increase or decrease employees pay (based on approved maximum rates), or request to change from one approved waiver service to another as long as he/she stay within the authorized budget.

Self-direction includes six core components: person-centered planning, individual control of budgets, independent support brokerage, financial management services, a backup plan, and quality enhancement and improvement.

Self-direction is firmly based in the principal of self-determination.

Self-determination refers to individuals or their designated representatives exercising control over their own lives, working toward achieving individualized life goals, and obtaining the skills and supports necessary to realize their visions for the future to build opportunities and relationships. The premise is that when individuals have control of their resources their quality of life will improve and the overall cost of services will decrease.

The individual is notified in writing of the approved budget and plan. The notice includes appeal rights should an individual disagree with the outcome. This process, which is in state regulation, is explained to individuals by the support coordinator and is available to the public from the State's web-site:

9 CSR 45-2.020 Appeals Procedures for Service Eligibility Through the Division of Developmental Disabilities.

<http://www.sos.mo.gov/adrules/csr/current/9csr/9c45-2.pdf>

Any time an individual's needs change, the support plan can be amended and a new budget can be prepared. If the new budget results in increased level of funding, the support plan and budget will be reviewed through the Utilization Review process before final approval is granted. If increases in service are needed immediately an immediate increase can be approved out of the annual budget by the individual or their representative. The team must then meet to determine if an increase in the annual budget is necessary. The person centered planning process including the budgeting process is explained to Individual by the support coordinator. Information on the person centered planning process and the Utilization Review process, which is in state regulation, are available to the public from the State's web-site:

9 CSR 45-2.017 Utilization Review Process

<http://www.sos.mo.gov/adrules/csr/current/9csr/9c45-2a.pdf>



Services are prior authorized on a yearly basis based on the needs of the individual. Individuals/guardians and designated representatives are informed of the amount of service that may be provided within that authorized period. The Fiscal Management Service (FMS) Provider provides monthly utilization reports.

The following services may be self-directed in all five DD waivers:

Community Specialist;
Personal Assistant;
Support Broker;

The support coordinator will assist the individual or his/her designated representative in understanding the choice of self-directed supports and transitioning from provider driven to self-directed services. They can also hire a support broker to provide information and assistance in order for them to self-direct their supports.

When an individual chooses to self-direct supports, the individual is the employer. A person may only self-direct services under one program. If self-directing services the individual shall only be enrolled in either, as eligible, the state plan PCA self-directed (Consumer Directed Services) or DD waiver self-directed services (SDS), but he or she cannot be enrolled in both at the same time.

An individual who is 18 years or older has the right to identify a designated representative. The designated representative is responsible for managing any employees and acting in the best interest of the individual, in accordance with the guiding principles of self-determination. If a representative has been designated by a court, the legal guardian will identify himself or another person as the representative.

The following people can be designated as a representative, as available and willing:

- A spouse (unless a formal legal action for divorce is pending)
- An adult child of an individual
- A parent
- An adult brother or sister
- Another adult relative of the individual
- Other representative — If the individual wants a representative but is unable to identify one of the above, the individual along with his/her support coordinator, and planning team, may identify an appropriate representative. The "other representative" must be an adult who can demonstrate a history of knowledge of the individual's preferences, values, needs, etc. The individual and his or her planning team is responsible to ensure that the selected representative is able to perform all the employer-related responsibilities and complies with requirements associated with representing one individual in directing services and supports.

A designated representative must:

- 1) Direct and control the employees' day to day activities and outcomes;
- 2) Ensure, as much as possible, that decisions made would be those of the individual in the absence of their disability;



- 3) Accommodate the individual, to the extent necessary, so that he/she can participate as fully as possible in all decisions that affect him; accommodations must include, but not be limited to, communication devices, interpreters, and physical assistance;
- 4) Give due consideration to all information including the recommendations of other interested and involved parties;
- 5) Embody the guiding principles of Self-Determination; and
- 6) Not be paid to provide any supports to the individual.

When working with the FMS, the individual and/or a designated representative are required to:

- Complete and submit for processing all required employer paperwork to establish the person serviced as an "employer of record" and send to the FMS;
- Not supplement wages to the Employee, nor self-direct any other program. Records maintained by the FMS will be the official records of the Employer's wages to workers, which will be reported to State and Federal tax authorities. The Employer/DR understands all earnings and taxes for Employees must be accurately reported to these taxing authorities;
- Recruit employees; interview employees and review references; once selected, have each potential employee fill out an employment packet and send to FMS organization for processing;
- Receive notice from the FMS organization that the employee candidate has passed the criminal background check before hiring him or her and allowing them to do any work for you;
- Hire employees;
- Train employees based on the Post Employment Training, then provide training documentation them to FMS organization within 30 days of hiring;
- Establish a work schedule for employees;
- Establish a list of tasks to be performed by employees that is based on the individual's ISP and the Job Description;
- Manage employees;
- Review employees' performance and provide feedback either to acknowledge good performance and/or point out areas that might need improvement;
- Terminate employment when necessary and report to the FMS organization; inform the FMS immediately of a terminated employee, make sure the employee has been fired in accordance with state department of labor fair firing practices and provide the FMS organization of the reason for firing so it can be documented in the employee's file;
- Review, approve and submit employees' time sheets to the FMS organization; if a time submitted does not correctly reflect the authorized hours worked, report any differences to the FMS organization; and work with employees to correct any errors;
- Ensure employees complete all Mandatory Documentation Forms;
- Complete the Mandatory Monthly Summary form that describes the progress made towards achieving your ISP goals and objectives and provide an overall picture of how things are going for the individual;
- Make sure employees have received and keep up with all required training and send to the FMS who will help track this (if trainings and certifications are not maintained, the employee will not be allowed to work);



- The FMS will maintain a personnel file for each employee that contains their training records, contractual agreements and a copy of their high school diploma or GED certificate;
- Create and maintain an emergency back-up plan in the event that an employee does not show up for work for any reason.

Service Documentation Maintained

All services provided must be adequately documented and signed by the person providing the support. Adequate documentation describing various covered activities or services in which the individual participated, progress towards goals when identified in the ISP, and unusual events

- Must be sufficient so that it is understandable, explains what was provided, and can be verified with reasonable certainty that the services were provided;
- Must be maintained by the employer for a period of six years;
- The employee is responsible for writing the documentation on the date they provide the service.
- Documentation must be signed by the employee providing the service.

The Division of DD contracts with a single Vendor Fiscal/Employer Agent (F/EA) Fiscal Management Service (FMS) organization to assist the employer with payroll-related functions. These functions include conducting a background screening of employee candidates, collecting and processing, employee qualification and other required human resource related forms and information (such as the IRS Form W-4, the US CIS Form I-9 and information necessary to register employees in the state's new hire reporting system), collecting and processing employees' time sheets, processing employees' payroll and the associated federal and state income tax withholding and employment taxes and other related payroll activities (such as issuing annual IRS Forms W-2 and refunding over-collected Medicare and Social Security taxes, as needed), and brokering workers compensation.

The methods used to determine the individual budget and process are as follows:

- Needs of the individual are identified in the ISP. The individual, along with the planning team, determines how the needs can be best met through natural supports, or paid supports and a budget is drafted to meet the individual's needs.
- The budget and ISP are reviewed by the Utilization Review (UR) Committee. UR considers the budget request in comparison with the level of funding that is approved for other individuals with similar needs and either recommends the regional director approve the budget or approve the budget with changes.
- The individual is notified in writing of the budget and ISP prior to implementing. The ISP should be signed by the individual or guardian prior to implementation, every attempt is made to obtain written approval and all attempts are documented in the individual's file. The notice includes appeal rights should an individual disagree with the ISP and budget.
- The written notice includes information on the individual's right to a fair hearing and offers help with the appeal process. They may first appeal to the regional director. If they are dissatisfied, they have appeal rights through both the Departments of Mental Health and DSS. While individuals are encouraged to begin with the Department of Mental Health's hearing system, they may skip this hearing process and go directly to the DSS, MO HealthNet Division (Single State Medicaid Agency) hearing system.
- Individual/guardians or designated representatives may request changes to budgets as needs change. For example, they may authorize more services be provided in one month and less



in another month. Or, if needs increase, they may request additional services. When additional services are requested, the budget must be approved through the UR process. If an increase in service is needed immediately, an immediate increase can be approved out of the annual budget by the individual or their representative. The team must then meet to determine if an increase in the annual budget is necessary.

- All regional offices administer the UR process according to state regulation.
- Individuals/guardians or designated representatives served by the Division of DD and providers are provided information on the UR process.

If an individual voluntarily requests to terminate Self Directed Support in order to receive services through an agency, the support coordinator will work with the individual or legal representative to select a provider agency and transition services to the agency model by changing prior authorizations based on the individual's needs. The support coordinator and other staff with the Regional Office will make every effort for the transition to be smooth and to ensure the individual is not without services during the transition. If SDS is terminated, the same level of services will be offered to the individual through a traditional agency model.

If the planning team determines the health and safety of the individual is at risk, the option of self-directing may be (involuntary) terminated. The option of self-directing may also be terminated by the Division of DD if there are concerns regarding the individual/guardian or designated representative's willingness to ensure employee records are accurately kept, or if the individual/guardian or designated representative is unwilling to supervise employees to receive services according to the plan, or unwilling to use adequate supports or unwilling to stay within the budget allocation.

Before terminating self-direction options, the support coordinator and other appropriate staff will first counsel the individual or legal representative to assist the individual or legal representative in understanding the issues, let the individual or legal representative know what corrective action is needed, and offer assistance in making changes. If the individual/guardian or designated representative refuses to cooperate, the option of self-directing may be terminated. However, the same level of services would be offered to the individual through an agency model.

Section E: Organized Health Care Delivery System (OHCDS)

Waiver services may be provided by an Organized Health Care Delivery System (OHCDS) defined in 42 CFR 447.10. An OHCDS must provide at least one Medicaid (otherwise known as MO HealthNet) service directly (utilizing its own employees) and may contract with other qualified providers to furnish other waiver services. Providers who meet this qualification may be enrolled with DSS as an OHCDS and may bill waiver services under the OHCDS provider number.

When OHCDS arrangements are used, all of the following apply:

- The OHCDS must have a written contract with any subcontractor who will provide waiver services;
- All subcontractors providing waiver services must meet applicable provider qualifications per 13 CSR 65-2;



- A qualified provider cannot be forced to contract with an OHCDS, but may enroll directly with the State's Medicaid agency, MO HealthNet;
- Waiver individuals must be able to select any qualified provider who has contracted with the OHCDS, or select a provider that is not contracted with the OHCDS but has enrolled directly with MO HealthNet;
- The OHCDS must maintain all documentation of services furnished by the subcontractor.

The OHCDS may bill only for the cost of waiver services and must pass on the reimbursement to the subcontractor. It may not retain excess payments and divert them to other uses. The amount billed to MO HealthNet cannot include administrative costs of the OHCDS.

Section F: Service Definitions

Assistive Technology

Available in all Waivers

Service Description

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

Electronic surveillance/monitoring systems using video, web-cameras, or other technology will only be available on an individual, case-by-case basis when an individual requests the service and the planning team agrees it is appropriate and meets the health and safety needs of the individual. Remote monitoring technology may only be used with full consent of the individual and their guardian and with written approval by the Due Process committee.

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

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

The provider must have safeguards and/or backup system such as battery and generator for the electronic devices in place at the monitoring base and the individual's residential living



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

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

Monitoring is performed by on-duty direct support staff employed by an ISL provider or by a personal assistant. The personal assistant may be employed by an agency, by the individual or their designated representative.

Personal Emergency Response System (PERS) is an electronic device that enables an individual at high risk of institutionalization to secure help in an emergency that is connected to a device and programmed to signal a response center once the help button is activated. The response center is staffed with trained professionals. The service is limited to those who live alone, live with others who are unable to summon help, or who are alone for significant portions of the day, have no regular caregiver for extended periods of time, and would otherwise require extensive routine supervision.

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

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

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

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



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

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

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

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

Costs are limited to \$3,000 per waiver year, per individual. For the Comprehensive, Support, and Autism waivers, the waiver year runs July 1st through June 30th; the PfH and MOCDD waiver year runs October 1st through September 30th. Exceptions are allowed to the \$3,000 annual spending limit for assistive technology with regional director or designee approval.

Provider Requirements

Agency must have a valid DMH contract to provide this service. The company shall be registered and in good standing with the Secretary of State Office.

Other Standard

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

Billing Information: Assistive Technology

Medicaid procedure code—

- Assistive Technology: A9999
 - Unit of Service: 1 job or item(s)



- Maximum Amount per Unit of Service: \$3000
- Cumulative Cost Per Individual Per Waiver Year: \$3000

Assistive Technology Service Documentation

The provider must maintain all documentation as per the requirements set forth in Section C of this manual. Assistive Technology documentation includes but is not limited to itemized invoices documenting the items purchased/rented and installed, and monthly service rates/expenses associated with device operation, upkeep, and maintenance. Documentation shall also include AT assessments information, as applicable to the device(s) purchased, as described in Division of DD Guideline #25.

Behavior Analysis Service

Available in all Waivers

Service Description

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

- An individual's Behavior Analysis Services are based on the Functional Behavioral Assessment (FBA) which identifies functional relationships between behavior and the environment including contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical variables related to the challenging behavior or situations;
- The plan should describe strategies and procedures to generalize and maintain the effects of the behavior support plan and to collect data to assess the effectiveness of the plan and fidelity of implementation of the plan;
- The specific skills and behaviors targeted for each individual should be clearly defined in observable terms and measured carefully by direct observation each session;
- The service shall include monitoring of data from continuous assessment of the individual's skills in learning, communication, social competence, and self-care guide to the scope of the individual support plan, which must include separate, measurable goals and objectives with clear definitions of what constitutes mastery;
- Data should be displayed in graphic format with relevant environmental variables that might affect the target behaviors indicated on the graph. The graph should provide indication of analysis via inclusion of environmental variables including medications and changes in medications, baseline or pre-intervention levels of behavior, and strategy changes;



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

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

NOTE: The Behavior Analysis Service is not intended to be an ongoing service. The following guidance shall be used when submitting authorizations to the UR Committee: Initial authorization for Behavior Analysis Service may not exceed 270 days,

- One subsequent authorization for Behavior Analysis Service may be approved, not to exceed an additional 90 days;
- Additional authorizations for Behavior Analysis Service must be approved by the Division Deputy Director or Assistant Director;
- Behavior Analysis Service may be authorized concurrent with Person Centered Strategies Consultation if working in conjunction with this service to support improved quality of life as foundation for behavioral services.

Senior Behavior Consultant

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

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

Behavior Intervention Specialist

The Behavior Intervention Specialist provides ongoing management of behavior analysis services. In more complex or involved situations the Behavior Intervention Specialist is responsible for managing the direct implementation of the recommendations and strategies of



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

Functional Behavioral Assessment (FBA)

FBA is a comprehensive and individualized strategy to identify the purpose or function of an individual’s behavior, develop and implement a plan to modify variables that maintain the problem behavior, and teach appropriate replacement behaviors using positive interventions. The FBA which identifies functional relationships between behavior and the environment including contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical variables related to the challenging behavior or situations. The FBA provides information necessary to develop strategies and recommendations to proactively address the challenging behaviors through skill development, prevention of problem situations and contributing reactions and interactions with significant persons in the life of the individual. These recommendations and strategies are more thoroughly delineated in the person’s behavior support plan. An FBA current within the past two years is necessary for other behavioral services to be used.

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



A FBA must result in a written document that evaluates if behavioral services are necessary or appropriate, explains the probable functions of the behavior with identification of situations that make it worse and/or have kept the behavior happening, what needs to occur to change the behavior, recommendations for likely effective strategies (not specifically described for implementation as in a behavior support plan) and likely duration and intensity of the service.

There will be situations in which an assessment will be needed to determine if other services or if behavior services might be appropriate. Not every instance of assessment will lead to behavioral services. If changes in situations occur, a new assessment might be warranted.

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

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

Service Limitations

FBA are limited to every two years unless the individual's behavior support plan documents substantial changes: to the individual's circumstances (living arrangements, school, and caretakers); in the individual's skill development; in the performance of previously established skills; or in frequency, intensity or types of challenging behaviors. A Behavior Intervention Specialist may under the direction of a Senior Behavior Consultant, conduct the data gathering for a functional assessment; however, the final interpretation and recommendations must be the work of the Senior Behavior Consultant.

This service is not restricted by the age of the individual; however, it may not replace educationally related services provided to individuals when the service is available under IDEA or other sources covered under an Individualized Family Service Plan (IFSP) through First Steps or otherwise available.

Provider Requirements

An individual or an agency must have a DMH contract.

- **Senior Behavior Consultant – Doctoral Degree:** Can be provided by an agency or an individual who has a Missouri state license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis as according to RSMO Chapters 337 and 376, specifically, 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224
- **Senior Behavior Consultant – Masters Degree:** Can be provided by an agency or an individual who has a Missouri state license as a Behavior Analyst or a licensed



- professional in psychology, social work, or professional counseling with training specific to behavior analysis as according to RSMO Chapters 337 and 376, specifically, 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224
- **Behavior Intervention Specialist** – Missouri State license as an Assistant Behavior Analyst or a licensed professional in psychology, social work or professional counseling with training specific to behavior analysis. RSMO Chapters 337 and 376, specifically, 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224, or the BIS provider must have a bachelor's degree and be working on a master's degree in behavior analysis; or have a master's degree and be completing licensure requirements for the behavior analyst.

This service may be provided by individuals who have completed coursework for behavior analyst licensure and working under the supervision of a Licensed Behavior Analyst; or completing the practicum work experience under the supervision of a Licensed Behavior Analyst.

No persons shall practice applied behavior analysis unless they are:

- (1) Licensed behavior analysts;
- (2) Licensed assistant behavior analysts working under the supervision of a licensed behavior analyst;
- (3) An individual who has a bachelor's or graduate degree and completed course work for licensure as a behavior analyst and is obtaining supervised field experience under a licensed behavior analyst pursuant to required supervised work experience for licensure at the behavior analyst or assistant behavior analyst level; or
- 4) Licensed psychologists practicing within the rules and standards of practice for psychologists in the state of Missouri and whose practice is commensurate with their level of training and experience.

A registered line therapist, under the direct supervision of a licensed behavior analyst, may:

- (a) Provide general supervision of an individual diagnosed with a pervasive developmental disorder diagnosis and other neurodevelopmental disorders, or serve as a line therapist under the supervision of a licensed behavior analyst;
- (b) Provide protective oversight of the individual; and
- (c) Implement specific behavioral interventions, including applied behavior analysis, as outlined in the behavior plan.

Any licensed healthcare professional may practice a component of applied behavior analysis, as defined in RSMo Section 337.300; or serve as a line therapist under the supervision of a licensed behavior analyst, if he or she is acting within his or her applicable scope of practice and ethical guidelines.

Billing Information: Behavior Analysis

Medicaid procedure code(s)–

- Senior Behavior Consultant: H2019 HO
 - Unit of Service: 15 minutes



- Maximum Units of Service: 32/Day (8 hours)
- Behavior Intervention Specialist: H2019
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 48/day (12 hours)
- Functional Behavior Assessment: H0002
 - Unit of Service: 1 assessment
 - Maximum Units of Service: 1 assessment/2 years

Behavior Analysis Service Documentation

Behavior Analysis providers must maintain service documentation as described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP and the individual behavior support plan. Progress notes should be reviewed for program fidelity and consistency, note any concerns, document contacts made with Behavior Intervention Specialist, family, caregivers, etc., any actions taken and modifications made to the behavior support plan. Written data shall be submitted to DMH authorizing staff as required. The Functional Behavior Assessment must not be billed until the assessment is complete and the FBA report has been finalized and received by the support team.

A copy of the written individual behavior support plan, interventions utilized, and progress notes during Behavior Analysis services, together with a written individual plan of care upon exiting intensive therapy will be filed in the individual's chart, located in the Regional Office or with the Targeted Case management entity with whom the individual is enrolled.

Communication Skills Instruction

Available in Comprehensive and Support Waivers only

Service Description

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

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

Communication Skills Instruction includes teaching a new communication system or language or enhancing a deaf individual's established minimal language skills, based on the



formal assessment of communication skills. Instruction sessions typically involve the people who support the deaf individual as well as the individual himself.

This service is a cost effective alternative to placement in an ICF/IDD. The unit of service is 15 minutes.

Provider Requirements

Individual – Must be a certified interpreter. An individual must have a DMH contract.

Billing Information: Communication Skills Instruction

Medicaid procedure code–

- Communication Skills Specialist: H2014
 - Unit of Service: 15 minutes
 - Maximum Unit of Service: 32/day (8 hours)

Communication Skills Instruction Service Documentation

Communication Skills Specialist providers must maintain service documentation as described in Section C of this manual, including detailed progress notes per dates of service and monthly progress notes (associated with objectives listed in the ISP), and a written evaluation done at least annually to establish need of service. An initial assessment of an individual's communication skills must be on file to document the need for instruction. Written data shall be submitted to DMH authorizing staff as required.

Community Specialist

Available in all Waivers

Service Description

A Community Specialist is used when specialized supports are needed to assist the individual in achieving outcomes in the ISP.

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

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

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

Community Specialist differs in service definition and in limitations of amount and scope from state plan TCM for person with developmental disabilities. In the latter, there are waiver administrative functions performed by a support coordinator through state plan TCM that fall outside the scope of community specialist, such as level of care determination, free



choice of waiver and provider, due process and right to appeal. Additionally, Division of DD support coordinators facilitate services and supports, authorized in the ISP, through the regional office utilization review and authorization process.

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

Provider Requirements

Providers of Community Specialist services must have a Bachelor's degree from an accredited university or college plus one year experience; be a Registered Nurse (with an active license in good standing, issued by the Missouri State Board of Nursing); or have an Associate's degree from an accredited university or college plus three years of experience. The service may be provided by either an individual provider or an employee of an agency.

An individual or an agency must also have a DMH contract.

An Independent Living Skills Development Provider or ISL Provider may provide community specialist services as long as they are also DMH certified or accredited by CARF, CQL or Joint Commission.

Community Specialist services may also be provided by a personal care provider, as long as they have a DMH contract and are enrolled to provide MO HealthNet personal care services.

Billing Information: Community Specialist

Medicaid procedure code–

- Community Specialist: T1016
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 96/day (24 hours)
- Community Specialist, Self-Directed: T1016 U2
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 96/day (24 hours)

Community Specialist Service Documentation

Providers must maintain plan of treatment and detailed record of intervention activity by unit to include referrals to other agencies, recommendations for change in treatment, and progress on behavioral/service objectives which are part of the ISP. Annual assessments of individual/family status are required. When the Community Specialist's employer of record is the individual or the individual's family, the individual or family is responsible for ensuring adequate documentation is maintained. Written data shall be submitted to DMH authorizing staff as required.

Community Transition

Available in Comprehensive Waiver only

Service Description

Transition services are one-time, set-up expenses for individuals who transition from an institution (ICF/IDD or Title XIX Nursing Home or other congregate living setting) to a less restrictive community living arrangement such as; a home, apartment, or other community-



based living arrangement. Congregate living settings shall include any provider-owned residential setting where MO HealthNet reimbursement is available, including the following:

- ICF/IDD
- Nursing Facilities
- Residential Care Facilities
- Assisted Living Facilities
- DD Waiver Group Homes

Examples of expenses that may be covered include:

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

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

The individual, their support coordinator, guardian (if applicable) and others involved in their support planning; will be required to fully explore the availability of natural supports, including donations of cash or donations of second-hand goods from charitable organizations and assistance from family and friends. The limit of \$3,000 to facilitate transition is not meant to be an entitlement. Every effort should be made to purchase the lowest cost items available, including second-hand goods when reasonable and appropriate.

If an individual received community-transition within the past 10 years, did not expend the full \$3,000, and is now moving to a less restrictive setting, the individual may use the service again, not to exceed a total of \$3,000 including the original expenditure and the current authorization. In addition, any household items that were purchased for that individual during their first transition from a congregate setting are the property of that person and the item will move with the individual. If the items purchased during the original transition are shared with housemates, the apportioned value of the item less reasonable depreciation must be used toward the cost of establishing the new household. The provider who was reimbursed the original transition cost will be responsible for purchasing items to facilitate the move at the amount determined in the calculation of proportional ownership and depreciation.

All purchases must be authorized and expended within 30 days prior to and after the move. If additional needs for household goods or furniture are identified more than 30 days after the



move, the individual will be expected to purchase these items using their own resources, or to use natural supports including donated items, gifts, second hand purchases, etc.

Community Transition Service Limitations

This service is limited to persons who transition from a congregate living setting to the waiver. The services must be necessary for the person to move from a congregate living setting and the need must be identified in the person's ISP. Total transition services are limited to \$3,000 per individual in the process of moving from a Title XIX Institution to the community. The limit of \$3,000 is not an entitlement and every effort should be made to utilize natural supports and to make frugal purchases, as described above. A unit of service is one item or expense.

Provider Requirements

This service can be provided by an individual contractor or an agency.

An agency can be a group home provider or an ISL provider, certified by DMH or accredited by CARF, CQL or Joint Commission, to provide Community Transition service. An agency can also be an agency contractor or a Division of DD regional office.

An individual or an agency must also have a DMH contract.

An individual contractor must have an applicable business license for service provided.

An agency contractor must be in good standing with the Secretary of State and have an applicable business license for the service provided.

A group home provider and ISL provider must be licensed according to 9 CSR 40-1,2,4,5 or certified according to 9 CSR 45-5.010, CARF, CQL or Joint Commission accreditation.

Billing Information: Community Transition

Medicaid procedure code–

- Community Transition: T2038
 - Unit of Service: 1 job or item
 - Maximum Total Cost per Unit of Service: \$3000
 - Lifetime Maximum: \$3,000

Community Transition Service Documentation

The provider must maintain all documentation as per the requirements set forth in Section C of this manual. Community Transition documentation includes but is not limited to itemized invoices documenting the items purchased, prior to billing.

Co-Worker Supports

Available in Comprehensive, Support and PffH Waivers



Service Description

The service allows the Division of DD, designated provider agencies to contract with a business to provide employer provided job supports as a part of the natural workplace. The supports will be provided directly to an individual to assist in the development of positive work-related habits, attitudes, skills and work etiquette directly related to their specific employment, as well as assisting the individual to become a part of the informal culture of the workplace. Employer provided job supports will include orienting the individual to health and safety aspects/requirements of their particular job. Individuals participating in this service are employed by a business in an integrated setting (working among peers without disabilities) and are earning at least minimum wage.

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

This service enables a continuum of employment supports that could include Job Preparation, Job Discovery, Community Employment Services with the least intensive support being provided through employer-provided job Co-Worker Supports. It is not necessary for an individual to progress along this continuum, however. Depending upon the individual's skills, abilities and needs, identified during the person-centered planning process, services may start at any point; skip steps in the continuum, or transition back into a service where more supports are available.

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

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

Service Limitations

An individual may not receive Job Discovery, Job Preparation, or Individual or Group Employment, at the same time they receive Co-Worker Supports. Individuals may receive Co-Worker Supports services during their first six months of employment. After the first six months, the contract is reduced to a lower stabilization rate based on job support intervention if needed. This service may continue as long as the individual has a job in an integrated workplace earning at least minimum wage.



Co-worker Supports Provider Requirements

The provider must have a DMH contract. To qualify, a description of supports to be provided by the subcontractor must be reviewed and accepted by the personal support team, including the support coordinator and other members designated by the individual, and the individual or his or her legal guardian prior to its execution.

These subcontracts are approved when it is determined that the individual's needs are best met by supports that supplement those provided by industry employees.

The provider must be an employer that is registered with the Missouri Secretary of State as a business in good standing.

Billing Information: Co-worker Supports

Medicaid procedure code–

- Co-worker Supports Service: H0038
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 32 units/day (8 hours)

Service Documentation

Providers must maintain service documentation described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Counseling

Available in Comprehensive and Support Waivers only

Service Description

Counseling Services include goal oriented counseling to maximize strengths and reduce behavior problems and/or functional deficits, which interfere with an individual's personal, familial, and vocational or community adjustment. It can be provided to individuals and families when the individual is present with the family. This service is not available to children who are eligible for psychology/counseling services reimbursed under the Healthy Children and Youth (EPSDT) program, or to adults when state plan psychology services are appropriate to meet the individual's need.

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

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



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

Provider Requirements

This service can be delivered by an individual or an agency.

An individual or an agency must also have a DMH contract.

An individual must be a professional counselor by being licensed as a psychologist, counselor or social worker licensed in accordance with RSMo Chapter 337.

An agency must enroll as a waiver provider employing psychologist, counselor or social worker licensed in accordance with RSMo Chapter 337.

Billing Information: Counseling Unit

Medicaid procedure code–

- Counseling: H0004 TG
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 32/day (8 hours)

Counseling Service Documentation

Counseling providers must maintain service documentation described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Crisis Intervention

Available in Comprehensive, Support and MOCDD Waivers only

Service Description

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

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

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



Specific crisis intervention service components may include the following:

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

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

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

Crisis Intervention services are expected to be of brief duration (4 to 8 weeks, maximum). When services of a greater duration are required, the individual should be transitioned to a more appropriate services program such as counseling, or respite. Crisis intervention needs for the eligible person that can be met through state plan, including EPSDT crisis services, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Waiver crisis intervention shall be provided above and beyond any state plan, including EPSDT crisis service that can meet the individual's need.

The scope of the waiver crisis intervention service is significantly above and beyond the scope of the state plan service and is meant to be provided by a team, not a single individual. It would be extremely rare for a crisis situation involving a DD waiver individual to be



resolved within 60 minutes, and by a person without specialized training working with people with developmental disabilities. Many crisis situations in the DD system may be due to an environmental situation where the individual does not have the language skills to communicate their discomfort or distress, and the average provider of traditional “talk therapy” may not have the experience, skills and educational background to appropriately address this need.

Provider Requirements

An agency must have a DMH contract.

A crisis agency; ISL lead agency; Independent Living Skills Development provider; or group home provider agency must have a psychologist, counselor or social worker licensed under RSMo Chapter 337 to provide this service.

This service can also be provided by Division of DD regional office or a habilitation center.

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

Billing Information: Crisis Intervention

Medicaid procedure code–

- Crisis Intervention, Professional: S9484
 - Unit of Service: Hour
 - Maximum Units of Service: 24/day
- Crisis Intervention, Technical: S9484 HM
 - Unit of Service: Hour
 - Maximum Units of Service: 24/day

Crisis Intervention Service Documentation

Crisis Intervention providers must maintain service documentation described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives, if applicable, listed in the ISP and the crisis situation. Written data shall be submitted to DMH authorizing staff as required.

Dental

Available in PfH Waiver only

Service Description

Those procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth.



Preventive dental treatment – Examinations, oral prophylaxes, and topical fluoride applications.

Therapeutic dental treatment – Treatment that includes, but is not limited to, pulp therapy for permanent teeth; restoration of carious permanent teeth; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable.

Service Limitations

Dental services for individuals under the age of 21 are not covered. Dental services for individuals under the age of 21 may be accessed under the state plan as a Healthy Children and Youth (HCY/EPSTDT) benefit.

Dental services through the PfH waiver for adults exclude the following:

- Any service that may be covered under the state plan Medicaid program.
 - This includes dental care related to trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury or for treatment of a medical condition without which the health of the individual would be adversely affected. Dental services may be provided to adults as state plan service if dental care is related to: Traumatic injury or jaw, mouth, teeth, or other contiguous (adjoining) sites.
 - Medical conditions related to or for a transplant patient, chemo/radiation therapy patient, systemic diseases; AIDS, other autoimmune diseases, uncontrolled diabetics, paraplegic, quadriplegic and; any other medical condition if left untreated, the dental problems would adversely affect the health of the individual resulting in a higher level of care.

Service unit is one visit, with a maximum of one unit per day. The combined cost of all PfH Waiver services authorized for an individual, including dental services, is limited to \$12,000 per year per individual. Dental services, authorized in combination with any other PfH Waiver service, are limited to \$12,000 per year for the individual.

Dental Provider Requirements

Individual Dentist

- Current licensure as a Dentist in the State of Missouri or bordering State;
- Have a DMH contract to provide this service;
- The individual Dentist may be enrolled with MO HealthNet to provide state plan dental care.
- RSMo 332.031 and 332.211

Agency-Dental Clinic

- Dentists within the Dental Clinic must have current licensure as a Dentist in the State of Missouri or bordering State;
- Licensed Dental Hygienists or Dental Assistants services may be included.



- A dentist is not required to enroll with the Department of Social Services as a provider of state plan dental care in order to provide dental services through the PfH Waiver.
- Dental Clinic may be enrolled with MO HealthNet to provide State Plan dental care.
- RSMo 332.031 and 332.211

Billing Information: Dental Unit

Medicaid procedure code–

- Dental Service: T2025
 - Unit of Service: 1 visit
 - Maximum Units of Service: 1/day

Service Documentation

The provider must maintain a plan of treatment and detailed record of all dental procedures by visit. Documentation must meet requirements set forth in 13 CSR 70-3.030.

Environmental Accessibility Adaptations (EAA) – Home/Vehicle Modifications

Available in all Waivers

Service Description

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

This service is not available for homes or vehicles owned by providers.

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

All adaptations must be recommended by an occupational or physical therapist. Plans for installation must be coordinated with the therapist to ensure adaptations will meet the needs



of the individual as per the recommendation. The service provider must document the identity of the PT or OT, including full name and Missouri license number.

All services shall be provided in accordance with applicable state or local building codes.

For environmental accessibility adaptations and specialized medical equipment and supplies a flat rate is not used. Bids or estimates of cost for a job, equipment, or supplies are obtained from two or more providers the individual chooses. A dollar amount is authorized for the provider with the lowest and best price if the price is reasonable based on the purchase experience of the regional office of similar jobs, equipment or supplies and does not exceed the annual maximum allowed for the service.

Costs are limited to \$7,500 per year, per individual for the Comprehensive, Support, Autism, MOCDD and PfH Waivers. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 for the Comprehensive, Support, and Autism Waivers. The annual limit corresponds to the waiver year which begins October 1 and ends September 30 each year for MOCDD and PfH Waivers.

The PT/OT component of the service will be authorized and reimbursed separately from the completion of the job, reimbursed in 15 minute increments at a price not to exceed the Medicaid Maximum Allowable for DD Waiver PT/OT in effect on the date of service, but paid under the DD Waiver procedure code for EAA.

If an individual's need cannot be met with the limit, an exception may be approved by the Regional Director and DD Deputy/Assistant Director to exceed the limit if this will result in a decreased need of one or more other services.

Provider Requirements

Must have applicable business license and meet applicable building codes; DMH Contract. An agency contractor must have a current, valid business license and are qualified to provide the EAA service as a described in the service definition, and provide evidence they are qualified to meet all applicable state and local building codes and construction standards for structures. Or, for vehicle modifications to allow for individual's increased vehicle access and use, a qualified provider is an agency contractor possessing a current valid business license and provide evidence they qualified to meet all required safety and construction standards associated with vehicle modifications.

Billing Information: Environmental Accessibility Adaptations-Home/Vehicle Modification

Medicaid procedure code–

- Environmental Accessibility Adaptations: S5165
 - Unit of Service: 1 completed job
 - Maximum Amount per Unit of Service: \$7,500
 - Cumulative Cost Per Individual Per Waiver Year: \$7,500
- Environmental Accessibility Adaptations, PT/OT component: S5165
 - Unit of Service: 15 minutes



- Price not to exceed the lesser of MO HealthNet maximum allowable rate for PT/OT or provider's contracted rate
- Maximum units PT/OT component: 8/day

Environmental Accessibility Adaptations-Home/Vehicle Modification Service Documentation

OT and PT providers conducting assessments/recommendations, as required for the environmental accessibility adaptations, must maintain documentation as per Section C of the DD Waivers Manual. OT and PT providers must maintain detailed progress notes per date of service. Written data shall be submitted to DMH authorizing staff as required.

The EAA provider must maintain all documentation as per the requirements set forth in Section C of this manual. Environmental Accessibility Adaptations documentation includes but is not limited to itemized invoices documenting the items purchased, prior to billing. The recommendation/assessment by the qualified PT or OT must be kept on file to document the need for the service. The date of service used should be the completion date of the adaptation/modification. At that time, the adaption/modification should have properly met the individual's needs.

Group Community Employment

Available in Comprehensive, Support and PfH Waivers only

Service Description

Group Community Employment is competitive work in an integrated work setting with ongoing support services for individuals with developmental disabilities. The service must be identified in the individual's support plan. Examples of group community employment may include mobile crews and other business based work groups employing small groups of workers with developmental disabilities in employment in the community. Group Community Employment must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those work places. The outcome of this service is sustained paid integrated community based employment where the individual has chosen to become employed (including self-employment situations) and have work experience leading to further career development and individual integrated community-based employment. The individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small group employment support does not include vocational services provided in facility-based work settings. Group Community Employment services are delivered in regular business and industry settings for groups of no more than six (6) workers with disabilities. With written approval from the Regional Director the group size may be up to eight (8) workers.

Group Community Employment services may include:

- Job development and placement;



- On-the-job training in work and work-related skills;
- Ongoing supervision and monitoring of the person's performance on the job;
- Training in related skills needed to obtain and retain employment such as using community resources and public transportation; and
- Negotiation with prospective employers.

Additional information about employment services

Provider supervision supports in this service are over and above those normally provided by the employer to any employee without a disability. Personal care/assistance may be a component of employment services, but may not comprise the entirety of the service. Individuals who receive job discovery and preparation services may also receive other day services. A participant's service plan may include two or more types of non-residential services. However, any combination of non-residential service may not be billed during the same period of the day.

While other services may also provide training in using community resources and public transportation, this particular training component is directly related to obtaining employment. While a waiver participant's ISP may also include other services that provide training in using community resources and public transportation, documentation will clearly indicate no duplication in services, in accordance with 13 CSR 70-3.030(2)(A) 6. Requiring a begin and end time for services reimbursed according to time spent in service delivery.

Documentation is maintained that the service is not available under a program funded under 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal Financial Participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a community employment program; 2) Payments that are passed through to users of community employment programs; or 3) payments for training that is not directly related to an individual's community employment program.

Provider Requirements

Providers must have a DMH HCB Medicaid Waiver contract for the provision of community employment services and must have one of the following: Licensed according to 9 CSR 30-5.050, certified according to 9 CSR 45-5.010 certification; or accredited by Commission on Accreditation of Rehabilitation Facilities (CARF), Counsel on Quality Leadership (CQL) or Joint Commission.

Staff Requirements

All direct-care staff must be 18 years of age and have a high school diploma or its equivalent.*

*Exemptions to HS diploma/GED requirement:

- Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be "grandfathered."



- Staff without diplomas or GEDs may be employed for up to one year while the person works to attain the requirement. The provider must document the staff's enrollment in school or GED courses.
- After July 1, 1996, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee's file.

Staff shall have training that covers at a minimum:

- Training, procedures and expectations related to this service in regards to following and implementing the individual's support plan. Training in implementation of each individual's current support plan/addendums shall be completed within one month of the implementation date of the current plan, or within one month of employment for new staff.
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support.
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.
- Training in positive behavior support curriculum approved by the Division of DD (within three months of employment).
- 14 hours of employment curriculum training, approved by the Division of DD, within six months of employment. An additional six hours of on the job training related to their job duties and supervised by qualified staff as defined in the provider contract.
- An additional four hours of continuing education is required annually.

Billing Information:

Group Community Employment: Medicaid procedure code:

Group Community Employment: H2023 HQ

- Unit of Service: 15 minutes
- Maximum Units of Service: 32/ day (8 hours)

Group Community Employment Service Documentation:

Group Community Employment providers must maintain service documentation as described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Providers must also document hours worked, wages earned and deductions taken; and regularly assess the continued presence and extent of involvement of the job coach as part of the review process. Written data shall be submitted to DMH authorizing staff as required.

Group Home

Available in Comprehensive Waiver only

Service Description

Group home services provide care, supervision, and skills training in activities of daily living, home management and community integration. The services are provided to groups of individuals in group homes, residential care centers, and semi-independent living



situations (clustered apartment programs) licensed or certified by DMH Licensure, certification and accreditation all meet the requirements of 45 CFR Part 1397 for board and care facilities. A unit of service is one day (24 hours).

Group Homes are owned and operated by public or private agencies under contract with the DMH Division of DD.

Group Homes are paid a per diem rate for each individual which covers:

- Staff intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, money management and household responsibilities. Also included are the salary, benefits, and training costs of direct program staff, supervisory staff, and purchased personnel who provide services in these areas;
- Habilitation supplies and equipment that are not specifically prescribed for one individual;
- Necessary staff supervision up to 24 hours per day; and
- Agency administration for habilitation services.

SUPPORTS AND SERVICES PROVIDED IN GROUP HOMES

Providers of group home services shall maintain appropriate levels of staff according to the following model:

Category I

Category I is a facility designed to provide a group living environment and minimum level of habilitation and supervision for persons with no severe medical needs or maladaptive behaviors.

- Staffing—day 1:8, evening 1:8, night 1:16
- Degreed Professional Management—minimum of 1.66 hours per week per each person served
- Characteristics of persons served—persons with mild to moderate levels of adaptive functioning who are ambulatory or mobile non-ambulatory, have basic self-help skills, but may need minimal assistance or prompting with daily living skills.

Category II

Category II is a facility designed to provide a group living and habilitation environment for persons with no severe medical needs or severe maladaptive behaviors, but who need self-help or habilitation training.

- Staffing—day 1:4, evening 1:4, night 1:8
- Degreed Professional Management—minimum of 2.5 hours per week per each person served



- Characteristics of persons served—persons with moderate to severe levels of adaptive functioning who are ambulatory or mobile non-ambulatory and who need training in basic self-help skills, socialization and daily living skills.

Category III

Category III is a specialized facility designed to provide a habilitation environment for persons with intensive physical or medical needs, severe maladaptive behaviors or other specialized care needs.

- Staffing—day 1:3, evening 1:3, night 1:6
- Degreed Professional management—minimum of 2.5 hours per week per each person served
- Characteristics of persons served—persons with various levels of adaptive functioning who are non-ambulatory and unable to provide for their own needs or ambulatory/non-ambulatory with intensive medical/physical needs or severe maladaptive behaviors.

In some cases, individual transportation is included in the rate, when the facility is equipped to routinely provide rides to Independent Living Skills Development provided at a stand-alone licensed or Independent Living Skills Development provider, which is not physically connected to the individual's residence or to community integration, etc. The DMH regional offices assure no duplication in payment for this service.

The service excludes the following:

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

Provider Requirements

This service can be provided by a Community Residential Facility or a Semi- Independent living arrangement.

The agency must have a DMH Home and Community Based Medicaid Waiver contract for the provision of group home services and one of the following:

A Community Residential Facility and a Semi-Independent Living (SIL) arrangement shall be licensed according to 9 CSR 40-1, 2, 4, 5; or they will be certified according to 9 CSR 45-5.010; or they may be accredited by CARF, CQL or Joint Commission. The group home staffing ratios shall follow Categories I-III described above in the group home service of this manual.



SUPPORTS AND SERVICES PROVIDED IN SEMI-INDEPENDENT (SIL) ARRANGEMENTS

Providers of residential supports who provide services in SIL arrangements shall maintain appropriate levels of staff sufficient to meet the needs of the individuals being served. Staffing plans deemed appropriate and sufficient are approved by the regional office using an individualized supported living budget. The budget shall reflect the approved staffing plan.

Staff Requirements

All direct-care staff must be 18 years of age and have a high school diploma or its equivalent.*

*Exemptions to HS diploma/GED requirement:

- Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be “grandfathered.”
- Staff without diplomas or GEDs may be employed for up to one year while the person works to attain the requirement. The provider must document the staff’s enrollment in school or GED courses.
- After July 1, 1996, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee’s file.

All direct-care staff shall have training that covers at a minimum:

- Training, procedures and expectations related to this service in regards to following and implementing the individual’s support plan. Training in implementation of each individual’s current support plan/addendums shall be completed within one month of the implementation date of the current plan, or within one month of employment for new staff.
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support.
- Have current certification in competency-based CPR and First Aid courses.
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.
- Training in positive behavior support curriculum approved by the Division of DD (within three months of employment).

Billing Information: Group Home

Medicaid procedure code–

- Group Home: T2016 HQ
 - Unit of Service: One (1) Day
 - Maximum Units of Service: 1/Day
- Group Home Intensive Rate: T2016 HQ
 - Unit of Service: One (1) Day
 - Maximum Units of Service: 1/Day
- Group Home Transition: T2016 HQ
 - Unit of Service: One (1) Day



- Maximum Units of Service: 1/Day

The date on which residential services begin shall be reimbursable. The date of discharge, transfer, death, or other departure shall not be considered as a reimbursable day for computation of payments.

Group Home Service Documentation

Group Home providers must maintain service documentation described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Host Home

Available in Comprehensive waiver only

Service Description

A Host Home is a private home, licensed or certified by the Division of DD, where a family accepts the responsibility for caring for up to three individuals with developmental disabilities. A Host Home offers a safe and nurturing home by giving guidance, support and personal attention. The provider plays an active role in the individual's team and the collaborative development of an ISP. The ISP is based on the team's knowledge of the individual's personal challenges, strengths, skills, preferences and desired outcomes. The ISP provides guidelines and specific strategies that address the person's needs in the social, behavioral and skill areas and is designed to lead to positive lifestyle changes. Living in a home environment presents daily opportunities to acquire and use new skills. The host family helps the individual participate in family and community activities and facilitate a relationship with the person and his/her natural family and the general community. They help the person learn and use community resources and services as well as participate in activities that are valued and appropriate for the person's age, gender and culture. The provider ensures that the person's identified health and medical needs are met and comply with licensure or certification regulations of the Division of Developmental Disabilities.

A single family host home may be licensed by and directly contract with DMH, or the host family may be directly employed by or under contract with an agency licensed by and under contract with DMH to provide Host Home services.

Host Home services include the following:

- a) Basic personal care and grooming, including bathing, care of the hair and assistance with clothing;
- b) Assistance with bladder and/or bowel requirements or problems, including helping the individual to and from the bathroom or assisting the individual with bedpan routines;
- c) Assisting the individual with self-medication or provision of medication administration for prescribed medications, and assisting the individual with, or performing health care activities;



- d) Performing household services essential to the individual's health and comfort in the home (e.g. necessary changing of bed linens or rearranging of furniture to enable the individual to move about more easily in his/her home);
- e) Assessing, monitoring, and supervising the individual to ensure the individual's safety, health, and welfare;
- f) Light cleaning tasks in areas of the home used by the individual;
- g) Preparation of a shopping list appropriate to the individual's dietary needs and financial circumstances, performance of grocery shopping activities as necessary, and preparation of meals;
- h) Personal laundry;
- i) Incidental neighborhood errands as necessary, including accompanying the individual to medical and other appropriate appointments and accompanying the individual for short walks outside the home;
- j) Skill development to prevent the loss of skills and enhancing skills that are already present that will lead to greater independence and community integration.

Payment to the Host Home is a flat monthly rate to meet the individual's support needs, and is exempt from income taxes. The Host Home will be paid on the basis of intensity and difficulty of care.

Parents of minor children, legal guardians, and spouses cannot be providers for their child, ward, or spouse.

People who live in a Host Home may also receive any other waiver service except for group home, individualized supported living, personal assistant, and Home Skills Development.

Payments for Host Home services do not include room and board, items of comfort or convenience, or the costs of home maintenance, upkeep, and improvement. Persons who receive Host Home services also shall not receive state plan personal care.

Provider Requirements

An individual or agency can provide this service. They must have a DMH contract and be licensed according to 9 CSR 40-6.010-6.114, or certified according to 9 CSR 45-5.010-.060. They can also be accredited through CARF, CQL, or Joint Commission.

Billing Information: Host Home

Medicaid procedure code—

- Host Home (Shared Living): S5136
 - Unit of Service: One (1) Day
 - Maximum Units of Service: 1/Day

Host Home Service Documentation

Host Home providers must maintain service documentation described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.



Independent Living Skills Development (ILSD)

Available in Comprehensive, Support, MOCDD and PFH Waivers

Service Description

Independent living skills development focuses on skill acquisition/development, retention/maintenance to assist the individual in achieving maximum self-sufficiency. This service assists the individual to acquire, improve and retain the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Independent Living Skills Development differs from the Personal Assistant service in that a personal assistant may directly perform activities or may support the individual to learn how to perform ADLS and IADLS as part of the service. Personal care/assistance may be a component of ILSD, but may not comprise the entirety of the service. Individuals who receive Group Home or Individualized Supported Living may receive this service; their group home or ISL budget will clearly document no duplication in service.

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

This service has three distinct components.

A provider is not required to make services available in a stand-alone facility to provide this service, but may choose only to provide the Home Skills Development and Community Integration components of this service.

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

Home Skills Development may not be provided to any waiver individual who also receives Host Home supports, as the Host Home provider is responsible for teaching home skills.



Day Services are provided at a stand-alone licensed or certified day program facility, which is not physically connected to the individual's residence, but may include incidental off-site activities at the discretion of the individual and provider. Day services assist the individual to acquire, improve and retain the self-help, socialization, adaptive, and life skills necessary at home or in the community. Costs for transporting the individual from their place of residence to the day program site are not included in the day service rate, and waiver transportation may be provided and separately billed. Services may be provided on an individual basis or for groups of individuals, up to six.

Community Integration teaches all skills needed to be part of a community, such as using public transportation, making and keeping medical appointments, attending social events, any form of recreation, volunteering, participating in organized worship or spiritual activities. Transportation costs related to the provision of this service in the community are included in the service rate. Services may be provided on an individual basis or for groups of individuals, up to four.

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

Home Skills Development may not be provided to any waiver individual who also receives Host Home supports, as the Host Home provider is responsible for teaching home skills. Individuals who live with host families may also receive day services and/or community integration.

Provider Requirements

Independent Living Skills Development (ILSD) agencies must have a DMH contract.

The agency will either be licensed as stated in 9 CSR 40-1, 2, 9; certified as stated in 9 CSR 45-5.010 certification; or accredited under CARF, CQL or Joint Commission.

State statute RSMo 630.050.

Staff Requirements

All direct-care staff must be 18 years of age and have a high school diploma or its equivalent.*

*Exemptions to HS diploma/GED requirement:

- Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be "grandfathered."
- Staff without diplomas or GEDs may be employed for up to one year while the person works to attain the requirement. The provider must document the staff's enrollment in school or GED courses.
- After July 1, 1996, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the



regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee's file.

All direct-care staff shall have training that covers at a minimum:

- Training, procedures and expectations related to this service in regards to following and implementing the individual's support plan. Training in implementation of each individual's current support plan/addendums shall be completed within one month of the implementation date of the current plan, or within one month of employment for new staff.
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support.
- Have current certification in competency-based CPR and First Aid courses.
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070. Program staff administering medication must have successfully completed a course on medication administration approved by the Division of DD regional office. Medication administration training must be updated every two years with successful completion.
- Training in positive behavior support curriculum approved by the Division of DD (within three months of employment).
- One year experience working with people with developmental disabilities, or in lieu of experience, must successfully complete training in the Missouri Quality Outcomes approved by the Division of DD regional office.

Billing Information: ILSD

Medicaid procedure code–

- Home Skills Development (provided at a person's residence), Individual and Group
 - S5108 Individual
 - Unit of Service : 15 minutes
 - Maximum Units of Service: 32/day (8 hours)
 - S5108 HQ Group
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 32/day (8 hours)
- Day Service (at a facility), Individual and Group
 - T2021 On-Site, Individual
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 32/day (8 hours)
 - T2021 HQ On-Site, Group
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 32/day (8 hours)
- Community Integration (in the community—not in the person's home or at an ILSD facility), Individual and Group
 - T2021 SE Individual
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 48/day (12 hours)
 - T2021 HQ SE Group
 - Unit of Service: 15 minutes



- Maximum Units of Service: 32/day (8 hours)

The codes for Day Service and Community Integration components to ILSD are actually the same codes and modifiers used for on-site and off-site day service currently. A participant's service plan may include two or more types of ILSD services. However, different types of ILSD services may not be billed during the same period of the day.

ILSD Service Documentation

ILSD providers must maintain service documentation described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Individual Community Employment

Available in Comprehensive, Support and Pfh Waivers only

Service Description

Individual Community Employment is competitive work in an integrated work setting (working among peers without disabilities) with on-going support services for individuals with developmental disabilities. The service must be identified in the individual's support plan. Individual Community Employment must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those work places. The outcome of this service is sustained paid integrated community based employment where the individual has chosen to become employed (including self-employment situations) and work experience leading to further career development. The individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Individual Community Employment services may include:

- Individualized job development and placement;
- On-the-job training in work and work-related skills;
- Ongoing supervision and monitoring of the person's performance on the job; and
- Training in related skills needed to obtain and retain employment such as using community resources and public transportation; and
- Negotiation with prospective employers.

Additional information about employment services

Provider supervision supports in this service are over and above those normally provided by the employer to any employee without a disability.

Personal care/assistance may be a component of employment services, but may not comprise the entirety of the service. Individuals who receive job discovery and preparation services may also receive other day services. A participant's service plan may include two or more types of non-residential services. However, any combination of non-residential service may not be billed during the same period of the day.



While other services may also provide training in using community resources and public transportation, this particular training component is directly related to obtaining employment. While a waiver participant's ISP may also include other services that provide training in using community resources and public transportation, documentation will clearly indicate no duplication in services, in accordance with 13 CSR 70-3.030(2)(A) 6. A begin and end time for services reimbursed according to time spent in service delivery is required.

Documentation is maintained that the service is not available under a program funded under 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Therefore the case records for individuals receiving Community Employment Services under the waiver will document that the participant was 1) Determined ineligible for services by the Missouri Department of Elementary and Secondary Education, Office of Adult Learning and Rehabilitation Service (VR), 2) Exhausted VR services, 3) Requires employment services not provided by VR, or 4) The person requests supports from a provider that does not participate in VR's system.

Federal Financial Participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a community employment program; 2) Payments that are passed through to users of community employment programs; or 3) Payments for training that is not directly related to an individual's community employment program.

Provider Requirements:

Providers must have a DMH HCB Medicaid Waiver contract for the provision of Individual Community Employment services and must have one of the following: Licensed according to 9 CSR 30-5.050, Certified according to 9 CSR 45-5.010 certification; or accredited by Commission on Accreditation of Rehabilitation Facilities (CARF), Counsel on Quality Leadership (CQL) or the Joint Commission.

Staff Requirements

All direct-care staff must be 18 years of age and have a high school diploma or its equivalent.*

*Exemptions to HS diploma/GED requirement:

- Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be "grandfathered."
- Staff without diplomas or GEDs may be employed for up to one year while the person works to attain the requirement. The provider must document the staff's enrollment in school or GED courses.
- After July 1, 1996, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee's file.

Staff shall have training that covers at a minimum:



- Training, procedures and expectations related to this service in regards to following and implementing the individual's support plan. Training in implementation of each individual's current support plan/addendums shall be completed within one month of the implementation date of the current plan, or within one month of employment for new staff.
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support.
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.
- Training in positive behavior support curriculum approved by the Division of DD (within three months of employment).
- 14 hours of employment curriculum training, approved by the Division of DD, within six months of employment. An additional six hours of on-the-job training related to their job duties and supervised by qualified staff as defined in the provider contract. An additional four hours of continuing education is required annually.

Billing Information: Individual Community Employment

Medicaid procedure code:

- Individual Community Employment: H2023
 - Unit of Service: 15 minutes
 - Maximum units of Service: 32/ day (8 hours)

Individual Community Employment Service Documentation:

Individual Community Employment providers must maintain service documentation as described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Providers must also document hours worked, wages earned and deductions taken; and regularly assess the continued presence and extent of involvement of the job coach as part of the review process. Written data shall be submitted to DMH staff as requested.

Individualized Supported Living (ISL)

Available in Comprehensive Waiver only

Service Description

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

Individualized Supported Living reflects these principles:

- People live and receive needed supports in the household of their choice which might include their family home, an apartment, condominium, or house in settings typical of people without disabilities. The selected housing should represent an adequate standard of living common to other citizens, allowing for reasonable protection and safety.



- Personal preferences and desires of those served are respected. Personal autonomy and independence are promoted. Individuals receiving services lead the planning, operation, and evaluation of services. The individual's self-direction and control leading toward self-governance are maximized through services rendered.
- Existing resources and natural supports, paid and unpaid, are maximized from the community at large.
- Training focuses on acquiring functional, useful skills within the community. Services minimize the need for skill transfer by providing training in the environment in which the skills are required.
- Services are “outcome” focused, addressing the quality of life being experienced in the present life style and not in the potential future implied by skill development/attainment.
- Services are provided based on individual needs not predicated on inflexible restrictions of specific funding mechanisms.
- Service goals are directed toward participation in the life of one's own community. As with any other citizen, this involves individual participation in civic activities and joining community organizations assuming those roles which are valued by the community.

If individuals choose to live with housemates, no more than four (4) individuals receiving ISL services may share a residence. Individuals receiving ISL services and sharing a home with housemates shall each have a private bedroom. Couples sharing a home where one or both of the couple receives ISL services may share a bedroom if they so choose.

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

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

Reporting Reduction in Services

In accordance with DMH's Purchase Of Service (POS) Waiver contract, when the lead agency delivers less than the hours and/or cost approved on a budget, the lead agency must report the reduction to the Missouri Medicaid and Compliance Unit (MMAC) on at least an annual basis. MMAC forwards the report to regional office who makes a one time adjustment to the budget.



ISL Budgets

ISL budgets include the following:

Direct Support, which includes:

- Direct Support Staff
- Professional Manager is included in the Direct Support Staff hourly rate and is responsible for
 - Staff training and supervision;
 - Quality enhancement monitoring;
 - Direct plan implementation for individuals as needed;
 - Monitoring implementation of outcomes;
 - Establishing information collection systems;
 - Writing monthly reviews;
 - Oversight/coordination of all the person's programs and services being received;
 - Coordinating the development of the ISP (scheduling, facilitation and summary document); and
 - Travel.
- Back-up and safety net supports, which include:
 - Maintenance of a phone number which will be answered 24 hours and to assure a regular point of contact for the person supported;
 - Provide a back-up plan should other supports fail to materialize as planned; and
 - Assuring communication regarding changes in the person's life (health, behavior, employment, etc.), with those important to the individual, including, but not limited to: Family/guardians, educational staff, employer, Independent Living Skills Development, case manager, physicians, etc.
- Administrative costs are included in the Direct Support cost hourly rate: This funding provides resources for the general operating costs of doing business; capital office costs, office supplies/equipment, office utilities; or contracted business expenses such as account/audit costs and management fees. Per 9 CSR 45-4.010 (1) (A) Administrative costs include: 1) staff time spent in administration, 2) staff time that cannot be directly associated with a specific service and 3) other costs that are not directly associated with a specific service. Administrative costs include management fees; home office and central office costs.

Other/ancillaries costs: client specific costs or services included in the ISP which are not part of the base rate or cannot be billed under another specified service.

Staffing Patterns:

Providers are required to submit household staffing patterns with each budget.



- The hours are based on needs documented in the individual's plan and must be specific to each person.
- Division of DD cannot support individuals living alone who require more than 16 hours of staffing per day. Staffing must be shared with one or two roommates.
- "Possible" days out are not allowed. Change in the budget will reflect the actual need.
- Budgets may allow for known exceptions. This includes, but may not be limited to: planned vacations from work, planned days off from school, commonly recognized holidays, known surgeries which may require leave from work and/or school.
- The need for overnight staff must be well documented and explained in the plan. If overnight awake staff is needed, it must be documented in the ISP.

Each person who receives ISL supports is required to have a monthly minimum of 30 minutes of contact by a Registered Nurse (RN). The amount will be specified in each person's ISP. The RN service will be authorized separately from the ISL budget and billed in 15 minute increments (2 units monthly per person minimum) under the waiver code ISL Nursing. ISL Nursing will be authorized in 6 month increments; enabling a provider flexibility within a 6 month time frame to provide services as needed, with the expectation that a minimum of 30 minutes be provided each month.

Room and board costs for an unrelated live-in personal caretaker: Room and board costs for an unrelated live-in personal caretaker, identified as the additional cost which an individual being served *must* incur for additional room, food and utilities occupied or consumed by such a care taker, may be added to the residential habilitation costs on the right side of the budget. This payment requires that the lead agency and/or the live-in caretaker contribute the same amount to the individual being served for payment of rent or utilities or for purchase of food. This payment is *not* available if the consumer resides in the home of a caregiver or in a home owned or leased by the lead agency.

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

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

Individuals who receive ISL services shall not receive waiver personal assistant services at their home but may receive this service outside the home as long as it is not included in the ISL budget. Individuals who receive ISL services may also receive Independent Living Skills Development, behavior analysis, employment, crisis intervention, etc. and other waiver services that are identified as needs through the person centered planning process and there is no duplication of the ISL service or included in the ISL budget.

Provider Requirements

ISL services must be provided by an agency with a DMH contract. State statute RSMo 630.050.



The provider shall be licensed according to 9 CSR 40-1, 2, 4, 6; certified according to 9 CSR 45-5.010; or accredited by CARF, CQL, or Joint Commission.

Staff Requirements

All direct-care staff must be 18 years of age and have a high school diploma or its equivalent.*

*Exemptions to HS diploma/GED requirement:

- Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be “grandfathered.”
- Staff without diplomas or GEDs may be employed for up to one year while the person works to attain the requirement. The provider must document the staff’s enrollment in school or GED courses.
- After July 1, 1996, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee’s file.

All direct-care staff shall have training that covers at a minimum:

- Training, procedures and expectations related to this service in regards to following and implementing the individual’s support plan. Training in implementation of each individual’s current support plan/addendums shall be completed within one month of the implementation date of the current plan, or within one month of employment for new staff.
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support.
- Have current certification in competency-based CPR and First Aid courses.
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.
- Training in positive behavior support curriculum approved by the Division of DD (within three months of employment).

Billing Information: Individual Supported Living

Medicaid procedure code–

- Individual Supported Living: T2016
 - Unit of Service: One (1) Day
 - Maximum Units of Service: 1/Day
- Individual Supported Living Transportation: T2001
 - Unit of Service: One (1) Mile
 - Maximum Units of Service: None
- Individual Supported Living Monthly Registered Nurse Oversight: T1002 TD
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 48/Day
- Individual Supported Living LPN (with Registered Nurse Oversight): T1003 TE
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 48/Day



The date on which residential services begin shall be reimbursable. The date of discharge, transfer, death, or other departure shall not be considered as a reimbursable day for computation of payments.

Individual Supported Living Service Documentation

ISL providers must maintain service documentation described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH staff as requested.

In-Home Respite

Available in Comprehensive, Support, MOCDD and Autism Waivers only

Service Description

In-home respite care is provided to individuals unable to care for themselves, on a short-term basis, because of the absence or need for relief of those persons normally providing the care. To be eligible for in-home respite care, the persons who normally provide care to the individual must be other than formal, paid caregivers. This service is not delivered in lieu of day care for children, nor does it take the place of independent living skills development programming for adults. While ordinarily provided on a one-to-one basis, in-home respite may include assisting up to three individuals at a time. The service is provided in the individual's place of residence. If the service includes overnight care, it must be provided in the individual's place of residence. A unit of service is 15 minutes or one day.

Provider Requirements

This service can be provided by an individual or an agency.

A provider of this service must have a DMH contract and shall not be the individual's spouse; the parent of a minor child (under age 18); nor the legal guardian.

An independent contractor must have a valid Missouri State professional license such as RN or LPN. State statute RSMo 630.050.

An agency can be an independent living skills development, ISL or a group home provider, licensed according to 9 CSR 40-1,2,4,5 and 9 CSR 40-1,2,4,7 certified according to 9 CSR 45-5.010 or accredited by CARF, CQL or Joint Commission, to provide in-home respite service. An agency may also be enrolled as a DSS state plan personal care provider. The agency-based provider of respite must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but must include at least the minimum training specified for the individual provider; the planning team may specify additional qualifications and training necessary to carry out the ISP.

Staff Requirements

All direct-care staff must be 18 years of age and have a high school diploma or its equivalent.*



*Exemptions to HS diploma/GED requirement:

- + Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be “grandfathered.”
- + Staff without diplomas or GEDs may be employed for up to one year while the person works to attain the requirement. The provider must document the staff’s enrollment in school or GED courses.
- + After July 1, 1996, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee’s file.

All direct-care staff shall have training that covers at a minimum:

- Training, procedures and expectations related to this service in regards to following and implementing the individual’s support plan. Training in implementation of each individual’s current support plan/addendums shall be completed within one month of the implementation date of the current plan, or within one month of employment for new staff.
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support.
- Have current certification in competency-based CPR and First Aid courses.
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.
- Training in positive behavior support curriculum approved by the Division of DD (within three months of employment).

Billing Information: In-Home Respite

Medicaid procedure code–

- In-Home Respite, Day: S5151
 - Unit of Service: One (1) Day
 - Maximum Units of Service: 1/Day
- In-Home Respite, Individual: S5150
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 40/Day (10 hours)
- In-Home Respite, Group: S5150 HQ
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 40/ Day (10 hours)

In-Home Respite Service Documentation

In-Home Respite providers must maintain service documentation described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Job Discovery

Available in Comprehensive, Support, and PfH Waivers only



Service Description

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

If it becomes clear that competitive integrated employment earnings that are at least minimum wage are not a reasonable goal and the individual does not plan to move forward toward competitive integrated employment then other supports and services which are designed to continue on a long term basis should be considered.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore, the case records for individuals receiving Job Discovery services under the waiver will document that the individual was: 1) Determined ineligible or inappropriate for services by the Missouri Department of Elementary and Secondary Education, Office of Adult Learning and Rehabilitation Service, known as Vocational Rehabilitation (VR), 2) Exhausted VR benefits, 3) VR does not cover the specific employment service the individual requires, or 4) the person requests supports from a provider that does not participate in VR's system.

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

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

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

Job discovery does not include services available under section 602 (16) and (17) of IDEA (U.S.C. 1401).

Provider Requirements

This service must be provided by an agency that has a DMH contract.

The Community Employment Provider shall be licensed according to 9 CSR 30-5.050; certified under 9 CSR 45-5.010; or accredited by CARF, CQL or Joint Commission.

Independent Living Skills Development providers shall be certified under 9 CSR 45-5.010; accredited by the CARF in the area of Employment and Community Services; or accredited by CQL or Joint Commission.



Staff Requirements

All direct-care staff must be 18 years of age and have a high school diploma or its equivalent.*

*Exemptions to HS diploma/GED requirement:

- + Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be “grandfathered.”
- + Staff without diplomas or GEDs may be employed for up to one year while the person works to attain the requirement. The provider must document the staff’s enrollment in school or GED courses.
- + After July 1, 1996, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee’s file.

All direct-care staff shall have training that covers at a minimum:

- Training, procedures and expectations related to this service in regards to following and implementing the individual’s support plan. Training in implementation of each individual’s current support plan/addendums shall be completed within one month of the implementation date of the current plan, or within one month of employment for new staff.
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support.
- Have current certification in competency-based CPR and First Aid courses.
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.
- Training in positive behavior support curriculum approved by the Division of DD (within three months of employment).
- There are 14 hours of employment curriculum training, approved by the Division of DD, within six months of employment. An additional six hours of on the job training related to their job duties and supervised by qualified staff as defined in the provider contract. An additional four hours of continuing education is required annually.

Billing Information: Job Discovery

Medicaid procedure code–

- Job Discovery, Individual, On-site: T2019
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 32/Day (8 hours)
- Job Discovery, Individual, Off-site: T2019 SE
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 32/Day (8 hours)

Job Discovery Service Documentation

Job Discovery providers must maintain service documentation described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. In addition, a career profile and employment



goal or career plan must be contained within the document. Written data shall be submitted to DMH authorizing staff as required.

Job Preparation

Available in Comprehensive, Support, and PffH Waivers only

Service Description

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

Services may be provided on site or off site in the community. Group Job Preparation service may include serving up to six (6) individuals at a time; however, with written approval from the RO director Job Preparation may serve up to eight (8) individuals.

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

This service is limited to two years, in any single continuous time period. (Not a cumulative life-time limit.)

Job preparation services must comply with 42 CFR §440.180(c)(2)(i). The need for services must be documented in the ISP. Services must be primarily habilitation in nature.

Participation in prevocational services is not a required pre-requisite for individual or small group community employment services provided under the waiver.

Documentation is maintained that the service is not available under a program funded under 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Provider Requirements

This service will be provided by an agency with a DMH contract.

The Community Employment Provider shall be licensed according to 9 CSR 30-5.050; certified under 9 CSR 45-5.010; or accredited by CARF, CQL or Joint Commission.



Independent Living Skills Development providers shall be certified under 9 CSR 45-5.010; accredited by the CARF in the area of Employment and Community Services; or accredited by CQL or Joint Commission.

Staff Requirements

All direct-care staff must be 18 years of age and have a high school diploma or its equivalent.*

*Exemptions to HS diploma/GED requirement:

- Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be “grandfathered.”
- Staff without diplomas or GEDs may be employed for up to one year while the person works to attain the requirement. The provider must document the staff’s enrollment in school or GED courses.
- After July 1, 1996, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee’s file.

All direct-care staff shall have training that covers at a minimum:

- Training, procedures and expectations related to this service in regards to following and implementing the individual’s support plan. Training in implementation of each individual’s current support plan/addendums shall be completed within one month of the implementation date of the current plan, or within one month of employment for new staff.
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support.
- Have current certification in competency-based CPR and First Aid course.
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.
- Training in positive behavior support curriculum approved by the Division of DD (within three months of employment).
- 14 hours of employment curriculum training, approved by the Division of DD, within six months of employment. An additional six hours of on the job training related to their job duties and supervised by qualified staff as defined in the provider contract. An additional four hours of continuing education is required annually.

Billing Information: Job Preparation

Medicaid procedure code:–

- Job Preparation, On-site, Individual: H2025
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 32/Day (8 hours)
- Job Preparation, On-site, Group: H2025 HQ
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 32/Day (8 hours)



- Job Preparation, Off-site, Individual: H2025 SE
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 48/Day (12 hours)
- Job Preparation, Off-site Group: H2025 HQSE
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 32/Day (8 hours)

Job Preparation Service Documentation

Job Preparation providers must maintain service documentation described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Occupational Therapy

Available in Comprehensive, Support, and PfH Waivers only

Service Description

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

The service provider must document the identity of the OT, including full name and Missouri license number.

Occupational therapy is covered under the Medicaid state plan for children and youth under the age of 21, so waiver OT is only for people age 21 and over.

Occupational therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Occupational therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first for persons before Developmental Disabilities waiver occupational therapy is provided.

Provider Requirements

This service must be provided by an individual or an agency that has a DMH contract and a state license for OT.

An individual must be certified according to RSMo 1990 334.735—334.746 as Occupational Therapist by AOTA or registered as a COTA. An Occupational Therapist must be either certified as an occupational therapist by the American Occupational Therapy Association or registered as a Certified Occupational Therapeutic Assistant (COTA). Requirements for registration as a COTA in Missouri are: Attainment of a two-year associate degree from an accredited college; successful completion of a state exam; and registration with the State



Division of Professional Registration. In addition, COTAs must receive supervision from a professional OT on a periodic, routine and regular basis.

An agency employing licensed occupational therapists may also employ registered COTAs supervised by licensed occupational therapists who are certified according to RSMo 1990 334.735—334.746 as Occupational Therapist by AOTA or registered as a COTA. An Occupational Therapist must be either certified as an occupational therapist by the American Occupational Therapy Association or registered as a Certified Occupational Therapeutic Assistant (COTA). Requirements for registration as a COTA in Missouri are: Attainment of a two-year associate degree from an accredited college; successful completion of a state exam; and registration with the State Division of Professional Registration. In addition, COTAs must receive supervision from a professional OT on a periodic, routine and regular basis.

Billing Information: Occupational Therapy

Medicaid procedure code—

- Occupational Therapy: 97535
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 8/Day (2 hours)
- Occupational Therapy, COTA: 97535
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 8/Day (2 hours)
- Occupational Therapy, Consultation: 97535
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 8/Day (2 hours)

Occupational Therapy Service Documentation

Occupational Therapy providers must maintain service documentation as described in Section C of this manual. This includes detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP, and a written evaluation done at least annually to establish need for service. The prescription by a physician and evaluation by a certified occupational therapist (OT) or certified occupational therapeutic assistant (COTA) under the supervision of an OT must be on file to document the need for the service. Written data shall be submitted to DMH authorizing staff as required.

Out of Home Respite

Available in Comprehensive, Support, MOCDD and Autism Waivers only

Service Description

Out of home respite is care provided outside the home in a licensed, accredited or certified waiver residential facility, ICF/IDD or State Habilitation Center by trained and qualified personnel. The need for this service has to be an identified need through the planning process which would include the individual, guardian if applicable, the primary caregiver, other family members, support coordinator, and any other parties the individual requests. The purpose of respite care is to provide planned relief to the customary caregiver and is not intended to be permanent placement. FFP is not claimed for the cost of room and board



except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Out of home respite is limited to no more than 60 days annually. This limit may be exceeded on an individual basis when necessary to protect the health and welfare of a waiver participant subject to the approval of both the county board and regional directors. Receipt of respite care does not necessarily preclude a participant from receiving other services on the same day. For example, a participant may receive day services (such as supported employment, adult day care, personal care, nursing care, etc.) on the same day as he/she receives respite care. Payment may not be made for respite provided at the same time when other services include care and supervision.

Provider Requirements

An agency shall have a DMH contract to provide this service.

A Community Residential Facility shall be licensed according to 9 CSR 40-1, 2, 3,4, 5; certified according to 9 CSR 45-5.010; or accredited by CARF, CQL or Joint Commission.

A State-operated ICF/IDD may also provide this service in accordance with 13 CSR 15-9.010 and in good standing with DHSS.

Staff Requirements

All direct-care staff must be 18 years of age and have a high school diploma or its equivalent.*

*Exemptions to HS diploma/GED requirement:

- Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be “grandfathered.”
- Staff without diplomas or GEDs may be employed for up to one year while the person works to attain the requirement. The provider must document the staff’s enrollment in school or GED courses.
- After July 1, 1996, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee’s file.

All direct-care staff shall have training that covers at a minimum:

- Training, procedures and expectations related to this service in regards to following and implementing the individual’s support plan. Training in implementation of each individual’s current support plan/addendums shall be completed within one month of the implementation date of the current plan, or within one month of employment for new staff.
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support.
- Have current certification in competency-based CPR and First Aid courses.
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.



- Training in positive behavior support curriculum approved by the Division of DD (within three months of employment).

Billing Information: Out of Home Respite

Medicaid procedure code–

- Out of Home Respite, Day: H0045
 - Unit of Service: One (1) Day
 - Maximum Units of Service: 1/Day
- Out of Home Respite: H0045
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 95/day (Note: 15 minute units are billed for dates the service is delivered on a less than 24 hour basis)

Out of Home Respite Service Documentation

Providers of the Out of Home Respite service must maintain attendance records and progress notes. The provider is required to follow procedures set forth under in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Personal Assistant

Available in all Waivers

Service Description

Personal assistant services include assistance with any activity of ADL or IADL. Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, care of adaptive equipment, meal preparation, feeding, and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation, and leisure activities. Assistance with IADLs includes accompaniment, cueing and minor problem-solving necessary to achieve increased independence, productivity and inclusion in the community. The services to be provided are solely for the individual and not household task expected to be shared with people living in the family unit. While ordinarily provided on a one-to-one basis, personal assistance may include assisting up to three (3) individuals at a time. With written approval from the regional director personal assistant services may be delivered to groups of four (4) to six (6) persons when it is determined the needs of each person in the group can be safely met.

Personal assistance may also include general supervision and protective oversight, which may be provided through remote monitoring technology covered under the Assistive Technology service also in this waiver.

The personal assistant may directly perform some activities or may provide support that promotes independence for the individual to learn to perform the activities.

Personal assistant is an active service which requires staff to be awake at all times.



The planning team determines the composition of the service and assures it does not duplicate, nor is duplicated by, any other service provided to the individual.

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

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

Relatives as Providers

Personal assistant services shall not be provided by an individual's spouse, or if the individual is a minor (under age 18) by a parent; or a guardian. Personal assistant services may otherwise be provided to a person by a member(s) of his or her family when the person is not opposed to the family member providing the service and the service to be provided does not primarily benefit the family unit, is not a household task family members expect to share or do for one another when they live in the same household, and otherwise is above and beyond typical activities family members provide for another adult family member without a disability.

In case of a paid family member the ISP must reflect:

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

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

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

Relation to State Plan Personal Care Services

Personal care services under the state plan differ in service definition, in limitations of amount and scope, and in provider type and requirements from personal assistant services under the waiver. When an individual's need for personal assistance is strictly related to



ADLs and can be met through the DSS state plan personal care program administered by the Division of Senior and Disability Services (DSDS), he or she will not be eligible for personal assistant services under the waiver, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. If self-directing services the individual shall only be enrolled in either, as eligible, the state plan PCA self-directed or DD waiver self-directed services, but he or she cannot be enrolled in both at the same time.

A DD waiver personal assistant may be authorized when:

- State plan limits on number of units for personal care are reached and more assistance with ADLs and/or IADLs is needed;
- Person requires personal assistance at locations outside of their residence;
- The individual has behavioral or medical needs and they require a more highly trained personal assistant than is available under state plan;
- The person shall exhaust agency-based state plan personal care prior to self-directing his or her waiver personal assistant services (may not self-direct state plan services).
 - A person may self-direct applicable DD waiver PAS if:
 - For a child under age 18, enrolled in the DD waiver, who is accessing state plan Agency Personal Care Attendant (PCA), and the child has additional needs as outlined in his or her Individual Support Plan (ISP), beyond the benefits and limitations of state plan PCA to meet this need, that can be supported through DD waiver PAS. Further, the legal authority (e.g., parents) of the child chooses self-directed PAS for the child based on assessed need in the child's ISP.
 - For an individual age 18 and over, who desires to self-direct DD waiver PAS, there shall be documentation to indicate this individual is not eligible to participate in the state plan Consumer-Directed Services program or Consumer-Directed PCA through the Independent Living Waiver, due to the individual not able to effectively manage Consumer-Directed PCA services without the supports of a representative.

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

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



When waiver personal assistant is authorized for children also eligible for state plan personal care, the support coordinator must consult and coordinate with the BSHCN service authorization system.

Non-Duplication of Services

Personal assistant services shall not duplicate other services. Personal assistance is not available to waiver individuals who reside in Group Homes. Individuals who receive ISL services shall not receive personal assistant services at their home but may receive this service outside the home, as long as it is not included in the ISL budget.

Residential Care and Assisted Living facilities licensed by the Department of Health and Senior Services are qualified providers of state plan personal care. Missouri state law requires RCFs and ALFs to provide assistance with activities of daily living and assistance with instrumental activities of daily living at the facility. State plan PC covers both ADLs and IADLs. Waiver personal assistance for DD waiver individuals living in a RCF or ALF may not duplicate or supplant State Plan personal care and is limited to assisting the waiver individual while they are out in the community.

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

Otherwise, the only limitation on hours provided is the individual's need for the service as an alternative to institutional care and the overall cost effectiveness of his or her ISP. Personal assistant services can occur in the person's home and/or community, including the work place. Personal assistant services shall not be provided concurrently with or as a substitute for ILS development. A participant's service plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.

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

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

Provider Requirements

Personal Assistant services can be self-directed if the individual chooses. For more information regarding self-directing this service see section D.

This service can also be provided by an agency or an individual contractor.

- An agency can be an ILSD or ISL provider to provide personal assistance services. An ILSD or ISL provider must be certified by DMH or accredited by CARF, CQL or Joint Commission. An agency may also be a state plan



personal care provider and be enrolled as a MO HealthNet personal care provider.

- An individual may be an Independent Contractor who must have a Missouri State professional license such as RN or LPN.

An Assistive Technology Agency providing personal assistant services through remote monitoring must have a valid DMH contract to provide this service.

Staff Requirements

All direct-care staff must be 18 years of age and have a high school diploma or its equivalent*.

*Exemptions to HS diploma/GED requirement:

- + Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be “grandfathered.”
- + Staff without diplomas or GEDs may be employed for up to one year while the person works to attain the requirement. The provider must document the staff’s enrollment in school or GED courses.
- + After July 1, 1996, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee’s file.

All personal assistants’ training must be documented and available upon request.

All personal assistants shall have training that covers at a minimum:

- Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual’s support plan. Training in implementation of each individual’s current support plan/addendums shall be completed within one month of the implementation date of the current plan, or within one month of employment for new staff.
- The rights and responsibilities of the employee and the individual, procedures for billing and payment, reporting and documentation requirements, procedures for arranging backup when needed, and who to contact within the Regional Office or Targeted Case Management entity.
- Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support.
- Training in event reporting and confidentiality.
- Have current certification in competency-based CPR and First Aid course.
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.



- Training in positive behavior support curriculum approved by the Division of DD (within three months of employment).
- Training to implement the behavior support plan, when included in the individual support plan. Personal assistants must be trained in an emergency intervention system (e.g., MANDT and NCI) approved by the Director of the Division of Developmental Disabilities or designee, when the ISP has indicated the risk for harm to self or others due to behavioral challenges.
- Training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; and in handling conflict and complaints.
- Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual to be served and identified by the team.

The individual or designated representative self-directing services may exempt CPR, First Aid, medications administration, and/or behavior intervention trainings if:

- Duties of the Personal Assistant will not require skills to be attained from the training requirement;
- The Personal Assistant named above has adequate knowledge or experience in:
 - CPR and First Aid;
 - Medication Administration;
 - Behavioral Intervention Training As needed, due to challenging behavior by the Individual, the assistant will also be trained in behavioral intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD.
 - These training exemptions under self-directed services must be justified in the individual's ISP.

Specialized Behavioral Personal Assistance

To assist in evaluating the need for specialized behavioral personal assistance the following must have been met:

- The interdisciplinary team has documented efforts to maximize the individual's ability to communicate with others;
- The interdisciplinary team has documented implementation of preventive strategies and outcomes of those strategies;
- The interdisciplinary team has identified and outlined the need to pursue more intensive behavior support strategies in the plan;
- An initial screening for medical, psychiatric or pharmacological causes has been completed; and
- Prior to approval of funding for specialized behavioral personal assistance the ISP has gone through the local ISP review process and has been reviewed by the Regional Behavior Supports Review Committee to determine the above have been completed.

The specialized behavioral personal assistant *must* adhere to the same requirements as outlined in the general personal assistant definition.

Additional requirements are as follows:



- Received training and holds current certification on positive behavioral support intervention strategies or Tools of Choice training that is approved by DMH;
- Agency Degreed Professional Manager has participated and successfully completed a DMH approved Positive Behavior Support Training or Tools of Choice training; and
- Must be trained on the specific individual's behavior support strategies.

For self-directed services, the specialized behavioral personal assistant shall not be exempt from emergency intervention training.

Specialized Medical Personal Assistance

To assist in evaluating the need for specialized medical personal assistance the following must have been met:

- The interdisciplinary team has identified that the individual's level of care requires either the:
 - Direct delivery of care by a licensed medical professional, or
 - Training, delegation and periodic supervision of care by a licensed medical professional.
 - Licensed Medical Professional as defined by the Nursing Practice Act Chapter 335. RSMo.
- The ISP documents the need and timeline for review of service.

The specialized medical personal assistant *must* adhere to the same requirements as outlined for the Individual Provider Employed by Individual or Family. Additional requirements are as follows:

- Received training related to the individual's medical needs as outlined in the ISP and as prescribed by the physician or advanced practice nurse.
- Received training by a licensed medical professional, demonstrated competency in all instructed procedures and are being delegated the task as determined by the supervising licensed medical professional. This delegation and individualized instruction is specific to this individual and may not be transferred to other individuals.

For self-directed services, the specialized medical personal assistant shall not be exempt from the following:

- CPR;
- First Aid; and
- Medication administration if providing medication administration.

Billing Information: Personal Assistant and Specialized Medical/Behavioral PAS

Medicaid procedure codes–

- Personal Assistant, Individual, Self-Directed: T1019 U2
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 96/Day (24 hours)
- Personal Assistant, Agency, Contractor: T1019
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 96/Day (24 hours)
- Personal Assistant, Group: T1019 HQ



- Unit of Service: 15 minutes
- Maximum Units of Service: 96/Day (24 hours)
- Team Collaboration, Self-Directed: G9007 U2
 - Units of Service: 15 minutes
 - Maximum Units of Service: 96/Day
- Personal Assistant, Specialized Medical/Behavioral: T1019 TG
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 96/Day (24 hours)
- Personal Assistant, Specialized Medical/Behavioral, Self -Directed: T1019 TGSE
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 96/Day (24 hours)

Personal Assistant and Specialized Medical/Behavioral PAS Documentation

Personal assistant providers must maintain service documentation described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Person Centered Strategies Consultant

Available in all Waivers

Service Description

This service involves consultation to the individual's support team to improve the quality of life for the individual through the development of and implementation of positive, proactive and preventative Person Centered Strategies and a modified environment and/or life style for the individual. Person Centered Strategies consultation involves evaluating a person's setting, schedule, typical daily activities, relationships with others that make up the supports for an individual including paid staff/paid family and unpaid natural supports. The evaluation leads to changes in strategies including such things as rearranging the home to reduce noise and stimulation, adding a personal quiet area to allow the individual to get away from annoying events, teaching skills to promote more positive interactions between the individual and supporting staff or family. Evaluation may involve identifying skills that would help the individual to have a better quality of life and assist the support staff/family to teach these meaningful skills to the individual and identify ways to proactively prevent problem situations and assisting the individual and support staff/family to use these new strategies and problem solving techniques for the individual. Such strategies developed could include: clarifying the expectations for the individual and all members of the support team, and establishing positive expectations or rules for the individual with the support team learning to change their system to support in these more positive ways, improving recognition of desirable actions and reduction of problematic interactions that might evoke undesirable responses from the individual. A large part of the consultation will involve assisting the support system to develop a sustainable implementation plan and to insure a high fidelity of implementation and consistency of use of the strategies to assist and support the individual.

Person Centered Strategy consultation might work towards improved quality of life for the individual through training of support persons and developing a way for the support system



to monitor and evaluate the interactions and systems to establish increased opportunities for teaching and practice of necessary skills by the individual, increasing recognition of desirable actions by the individual and the support team, increased frequency and types of positive interactions by support persons with and by the individual, and assisting the individual and support team to arrange practice opportunities such as social skills training groups or arranging a system of coaching and prompting for desirable actions in situations that commonly are associated with problems. The consultant might establish and lead such practice opportunities while coaching support persons to continue the practice when the service is discontinued.

The unit of service is 15 minutes.

This service is not to be provided for development or implementation of behavior support plans or functional assessment as these services require licensure as a behavior analyst, psychologist, counselor or social worker with specialized training in behavior analysis. However, this service might work in conjunction with a behavior analysis service provider to develop and establish a support system that can implement strategies towards a good quality of life for the individual.

PCSC differs from the Behavior Analysis Service in that PCSC the focus and whole scope of the service is on identifying barriers to a good quality of life and improving proactive, preventative and teaching based strategies to increase desirable, healthy skills and thus reduce problem situations. In addition, the PCSC will require providers with a less involved level of training and experience than BAS.

Outcomes expected for this service are as follows:

1. Written document describing the results of the evaluation of the system to identify problem situations, strategies and practices and relate these to the quality of life for the focus individual.
2. Summary of recommended strategies developed with the support team to address the identified problems and practices based on the evaluation.
3. Training for the individual and support team to implement the strategies with fidelity and collect data to determine effectiveness of the strategies that will assist the individual in achieving a good quality of life.
4. A written document that is incorporated into the Individual Support Plan to ensure the implementation of the new strategies with fidelity and consistency by the support team after the PCSC is completed.

This is a short term service that is not meant to be on going, the typical duration of service is to be twelve months or less.

Psychology/Counseling services under EPSDT do not include Person Centered Strategies services.



Documentation for the service

1. Identification of the outcome being addressed during the service unit(s) for a particular session.
2. Description of progress towards the outcome.
3. Actions steps and planning for the next service sessions including a timeline and steps necessary to achieve the outcome.

Provider requirements

An agency or an individual must have a DMH contract.

This service can be provided by an Individual or an agency who is a Qualified Person Centered Strategies Consultant. A Person Centered Strategies Consultant is a person with a bachelor's degree with special training, approved by the Division, related to the theory and practice of Person Centered Strategies for individuals with intellectual and developmental disabilities, or Applied Behavior Analysis and implementation of Person Centered Approaches.

Training will be approved by Division of DD staff if the training syllabus describes positive, proactive intervention strategies, quality of life variables and evaluation and improvement strategies and system wide implementation of evidenced based practices. This includes, for example: The Tools of Choice training with additional coaching of tools training; college course work, for example, within a special education department involving implementation of Tiered Supports strategies; training from a state agency on implementation of tiered supports and person centered strategies and quality of life.

Billing Information: Person Centered Strategies Consultant

Medicaid procedure code–

- Person Centered Strategies Consultant: H0004 HK
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 32/Day (8 hours)

Person Centered Strategies Service Documentation

The provider must maintain service documentation as described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Physical Therapy

Available in Comprehensive, Support and PfH Waivers only

Service Description

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



Services may include consultation provided to families, other caretakers, and habilitation services providers. Physical therapy services may not be carried out by a paraprofessional. A unit of service is 15 minutes.

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

The service provider must document the identity of the physical therapist, including full name and Missouri license number.

Physical therapy is covered under the Medicaid state plan for children and youth under the age of 21, so waiver Physical therapy is only for people age 21 and over.

Physical therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Physical therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first before the waiver physical therapy is provided. Children have access to EPSDT services.

Provider Requirements

An individual to provide physical therapy service shall have a DMH contract as well as be licensed per RSMo 1990 334.530–334.625.

Billing Information: Physical Therapy

Medicaid procedure code–

- Physical Therapy: 97110
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 8/Day (2 hours)
- Physical Therapy, Consultation: 97110
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 8/Day (2 hours)

Physical Therapy Service Documentation

Physical therapy providers must maintain service documentation as described in Section C of this manual. Provider must maintain detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP; and a written evaluation done at least annually to establish need for service. Following a physical motor evaluation, the prescription by a physician must be on file to document the need for the service. Written data shall be submitted to DMH authorizing staff as required.

Professional Assessment and Monitoring

Available in all Waivers

Service Description

Professional Assessment and Monitoring (PAM) - A face to face visit to assess individual and/or care environment, evaluate need and plan and/or provider appropriate support including special instructions for caregivers to reduce the need for habitual health



professional intervention and promote optimal level of care. PAM may include physical assessments, medication set up, injections, nursing diagnosis, complex nursing treatment, nutritional care plans, nutritional counseling (if the nutritional problem or condition is of such a degree of severity that counseling is beyond that normally expected as a part of standard medical management), and nutritional therapy services, not otherwise covered by Medicare or Medicaid state plan services. A nursing task is defined as complex if it requires consideration of a number of factors in order to perform the procedure or if it requires judgment to determine how to proceed from one step to another. Any changes in health status are to be reported to the physician and support coordinator as needed. Written reports of the visit are required to be sent to the support coordinator. This service may be provided by a licensed registered professional nurse, or a licensed practical nurse under the supervision of a registered nurse, or a licensed dietitian to the extent allowed by their respective scope of practice in the State of Missouri.

This service must not supplant Medicaid state plan services or Medicare services for which an individual is eligible. Excluded services include Diabetes Self-Management Training available under the state plan; and medical nutrition therapy service prescribed by a physician for persons who are Medicare eligible and who have diabetes or renal diseases.

Staff Requirements

Service provider must be licensed in Missouri as a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Dietician.

Provider Requirements

PAM service providers must have a valid DMH contract and/or provide services through an Organized Health Care Delivery System for provision of PAM services. The contractor shall not be the consumer's spouse, a parent of a minor child (under age 18), nor a legal guardian.

Billing Information: Professional Assessment and Monitoring

Medicaid procedure code–

- Professional Assessment and Monitoring, Registered Nurse: T1002
 - Unit of Service: 15 Minutes
 - Maximum Units of Service: 48/Day (12 hours)
- Professional Assessment and Monitoring, Licensed Practical Nurse: T1003
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 48/Day (12 hours)
- Professional Assessment and Monitoring, Dietician: S9470
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 48/Day (12 hours)

Professional Assessment and Monitoring Service Documentation

Professional Assessment and Monitoring providers must maintain a plan of treatment and detailed record of intervention activities by unit of service. The provider is required to follow procedures set forth under “Documentation” found earlier in this section.



Specialized Medical Equipment and Supplies (Adaptive Equipment)

Available in all Waivers

Service Description

Specialized medical equipment and supplies includes devices, controls, or appliances, specified in the ISP, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This also includes items necessary for life support; ancillary supplies and equipment necessary for the proper functioning of such items; durable and non-durable medical equipment and supplies; and equipment repairs when the equipment, supplies and repairs are not covered under the Medicaid State Durable Medical Equipment (DME) plan. Incontinence supplies are included.

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the state plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

For environmental accessibility adaptations and specialized medical equipment and supplies a flat rate is not used. Bids or estimates of cost for a job, equipment, or supplies are obtained from two or more providers the individual chooses. A dollar amount is authorized for the provider with the lowest and best price if the price is reasonable based on the purchase experience of the regional office of similar jobs, equipment or supplies and does not exceed the annual maximum allowed for the service.

Costs are limited to \$7,500 per year, per individual for the Comprehensive, Support, MOCDD, Autism and PfH Waivers. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 for the Comprehensive, Support and Autism Waivers. The annual limit corresponds to the waiver year which begins October 1 and ends September 30 each year for MOCDD and PfH Waivers.

If an individual's need cannot be met with the limit, an exception may be approved by the Regional Director and DD Deputy/Assistant Director to exceed the limit if this will result in a decreased need of one or more other services.

Other specialized equipment, supplies and equipment repair needs for the eligible person that can be met through state plan, including EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Other specialized equipment, supplies and repairs under the Developmental Disabilities waivers shall be provided above and beyond any state plan, including EPSDT, equipment, supplies, and repair service that can meet the individual's needs. Further, this waiver service may also be authorized for items/repairs not covered under state plan and falls within the waiver service definition described above.



PROOF OF DELIVERY

Providers must maintain proof of delivery documentation in their files for every item provided. Documentation must be maintained in the provider's files for five years. Proof of delivery is required in order to verify that the beneficiary received the item or supply.

For the purpose of the proof of delivery information provided below, designee is defined as: "Any person who can sign and accept the delivery of durable medical equipment on behalf of the participant." Providers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a participant (i.e., acting as a designee on behalf of the beneficiary).

Providers may not bill for an item prior to receipt of documentation of proof of delivery. In addition, for items of durable medical equipment that require fitting, set-up, and/or instructions, a provider cannot bill prior to providing proper set-up, fitting and instruction for items of durable medical equipment that require fitting, set up and/or instruction. Documentation of any set-up, fitting and/or instructions provided must be included in the provider's records.

DIRECT DELIVERY

Providers may deliver directly to the participant or their designee. An example of proof of delivery made directly to a participant is having a signed delivery slip. It is recommended that the delivery slip include:

The participant's name;
The quantity delivered
A detailed description of the item being delivered;
The brand name; and
The serial number (if applicable).

The date of signature on the delivery slip must be the date that the item/supply was received by the participant or designee. In instances where the item/supply is delivered directly by the provider, the actual date the participant received the supply/item shall be the date of service on the claim.

MAIL ORDER/SHIPPING SERVICE DELIVERY

If a provider uses a shipping service or mail order, an example of proof of delivery would include the services tracking slip (must include the date delivered) and the supplier's own shipping invoice. If possible, the provider's records should also include the delivery service's package identification number for the package sent to the participant. The shipping services tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and the date delivered. Providers should use the shipping date as the date of service on the claim.

SUPPLY REFILLS

Items supplied as refills to the original order, the provider must contact the participant or caregiver prior to dispensing the refill and not automatically ship on a pre-determined basis,



even if authorized by the participant. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modification to the order. Contact with the participant or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date.

For all items that are provided on a recurring basis, providers are required to have contact with the participant or caregiver/designee prior to dispensing a new supply of items. Providers must not deliver refills without a refill request from a participant. Items delivered without a valid, documented refill request are not covered and may not be billed to the participant.

Providers must not dispense a quantity of supplies exceeding a participant's expected utilization. Providers must stay attuned to changed or atypical utilization patterns on the part of their clients. Providers must verify with the ordering physicians when applicable that any changed or atypical utilization is warranted.

The date of service for item supplied as refills to the original order may be the actual delivery date or ship date depending on the method of delivery or within three calendar days of the delivery date or ship date. For example, if an item is delivered by the supplier on June 1, the date of service billed on the claim may be June 1, June 2, June 3 or June 4. This flexibility is allowed to ensure a participant is able to receive the refill of supplies without a gap in service and the provider is able to bill for supplies provided.

Provider Requirements

This service must be provided by an agency that is registered and in good standing with Missouri Secretary of State and have a DMH Contract. The provider must be enrolled with MO HealthNet as a state plan Durable Medical Equipment Provider or currently possess a DMH contract to provide any other DD waiver service.

Billing Information: Specialized Medical Equipment and Supplies

Medicaid procedure code–

- Specialized Medical Equipment and Supplies: T2029
 - Unit of Service: 1 order with one or more items
 - Maximum Amount per Unit of Service: \$7,500
 - Cumulative Cost Per Individual Per Waiver Year: \$7,500

Documentation

The provider must maintain all documentation as per the requirements set forth in Section C of this manual. Specialized Medical Equipment and Supplies documentation includes but not limited to itemized invoices documenting the items purchased.



Speech Therapy

Available in Comprehensive, Support, and PfH Waivers only

Service Description

Speech Therapy is for individuals who have speech, language or hearing impairments. Services may be provided by a licensed speech language therapist or by a provisionally licensed speech therapist working with supervision from a licensed speech language therapist. The individual's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. The need for services must be identified in the ISP and prescribed by a physician. Speech therapy provides treatment for delayed speech, stuttering, spastic speech, aphasic disorders, and hearing disabilities requiring specialized auditory training, lip reading, signing or use of a hearing aid.

Services may include consultation provided to families, other caretakers, and habilitation services providers. A unit of service is 15 minutes.

Waiver providers must be licensed by the State of Missouri as a Speech Therapist. The Medicaid Waiver enrolled provider may employ a person who holds a provisional license from the State of Missouri to practice speech/language pathology or audiology. Persons in their clinical fellowship may be issued a provisional license. Clinical fellowship is defined as the supervised professional employment period following completion of the academic and practicum requirements of an accredited training program. Provisional licenses are issued for one year. Within 12 months of issuance, the applicant must pass an exam promulgated or approved by the board and must complete the master's or doctoral degree from an institution accredited by the Council on Academic Accreditation of the American Speech-Language-Hearing Association in the area in which licensing is sought. Provisionally licensed speech therapists must receive periodic, routine supervision from their employer, a Medicaid waiver enrolled speech therapy provider.

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

The individual's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. Services must be required in the ISP and prescribed by a physician. This service may not be provided by a paraprofessional. The service provider must document the identity of the ST, including full name and Missouri license number.

Speech therapy is covered under the Medicaid state plan for children and youth under the age of 21, so waiver Speech therapy is only for people age 21 and over.

Speech therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Speech therapy through EPSDT for



eligible persons under age 21 shall be provided and exhausted first for persons before Developmental Disabilities waiver speech therapy is provided.

Provider Requirements

This service shall be provided by a Licensed Speech Therapist per RSMo 1990 345.050 or certified in accordance with provisional licensing per RSMo 1998 345.022, employed and supervised by a Licensed Speech Therapist. The individual also must have a DMH contract to provide this service.

Billing Information: Speech Therapy

Medicaid procedure code–

- Speech therapy: 92507
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 8/Day (2 hours)
- Speech Therapy, consultation: 92507
 - Unit of Service: 15 Minutes
 - Maximum Units of Service: 8/Day (2 hours)

Speech Therapy Service Documentation

Speech Therapy providers must maintain service documentation as described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP; and a written evaluation done at least annually to establish need for service. The need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist and prescribed by a physician. The evaluation and prescription must be kept on file. Written data shall be submitted to DMH authorizing staff as required.

Support Broker

Available in all Waivers

Service Description

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

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

A Support Broker provides the individual or designated representative with information and assistance (I&A) to:

- Establish work schedules for the individual's employees based upon their ISP;
- Help manage the individual's budget when requested or needed;
- Seek other supports or resources outlined by the ISP;



- Define goals, needs and preferences, identifying and accessing services, supports and resources as part of the person centered planning process which is then gathered by the support coordinator for the ISP;
- Implement practical skills training (recruiting, hiring, managing, terminating workers, managing and approving timesheets, problem solving, conflict resolution);
- Develop an emergency back-up plan;
- Implement employee training;
- Promote independent advocacy, to assist in filing grievances and complaints when necessary;
- Include other areas related to providing I&A to individuals/designated representative to managing services and supports;

Support Brokers must have a background screening per the Division of DD, be at least 18 years of age and possess a high school diploma or GED.

The Support Broker must have experience or Division of DD approved training in the following areas:

- Ability, experience and/or education to assist the individual/designated representative in the specific areas of support as described in the ISP;
- Competence in knowledge of Division of DD policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Understanding of Support Broker responsibilities, of advocacy, person-centered planning, and community services;
- Understanding of individual budgets and Division of DD fiscal management policies.

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

Support Broker services do not duplicate Support Coordination.

A Support Broker shall not be a parent, guardian or other family member. The Support Broker cannot serve as a personal assistant or perform any other waived service for that individual.

Provider Requirements

This service can be self-directed or provided by an agency or individual. For more information regarding self-directing this service see section D.

An agency and an individual must have a DMH contract. State statute RSMo 630.050.

For an agency to provide this service it has to be certified by DMH Certification for ISL or day habilitation; or accredited by CARF/CQL/Joint Commission accredited for ISL or Independent Living Skills Development that employs qualified Support Brokers.



Individual Support Broker who is Age 18: Meets minimum training requirements; agreement with Division of DD regional office; agreement with individual/designated representative; supervised by individual/designated representative.

Billing Information: Support Broker

Medicaid procedure code–

- Support Broker, Individual, Self-Directed: T2041 U2
 - Unit of Service: 15 Minutes
 - Maximum Units of Service: 32/Day (8 hours)
- Support Broker, Agency: T2041
 - Unit of Service: 15 Minutes
 - Maximum Units of Service: 32/Day (8 hours)

Support Broker Service Documentation

Support Broker providers must maintain service documentation as described in Section C of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Temporary Residential Service

Available in PfH Waiver only

Service Description

Temporary Residential Service is care provided outside the home in a licensed, accredited or certified waiver residential facility, ICF/IDD or State Habilitation Center by trained and qualified personnel. The need for this service has to be an identified need through the planning process which would include the individual, guardian if applicable, the primary caregiver, other family members, support coordinator, and any other parties the individual requests. The purpose of temporary residential is to provide planned relief to the customary caregiver and is not intended to be permanent placement. If the needs of the individual exceed the Partnership for Hope Waiver annual cap, or the ISP identifies an ongoing need for out of home services, then the planning team would work to transition the individual to another Developmental Disabilities Waiver to meet their needs. FFP is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

The service is limited to 60 days per year. This limit may be exceeded on an individual basis when necessary to protect the health and welfare of a waiver participant subject to the approval of both the county board and regional directors.

Provider Requirements

Temporary Residential service providers must have a DMH contract and one of the following:

- A valid DMH community residential facility license under 9 CSR 40-1,2,4,5; or certified by the DMH under 9 CSR 45-5.010;
- Accreditation by the CARF, in the area of Community Living Programs;
- Accreditation by The Council for Quality & Leadership for Persons with developmental disabilities (The Council); or



- Certified ICF/IDD and Division of DD Habilitation Centers may be enrolled to provide temporary residential.

Service Limitations

Temporary Residential service may not be provided for a period of less than 1 day (24 hours) and no more than 60 days per year. This limit may be exceeded on an individual basis when necessary to protect the health and welfare of a waiver participant subject to the approval of both the county board and regional directors. Receipt of temporary residential care does not necessarily preclude a participant from receiving other services on the same day. For example, a participant may receive day services (such as supported employment, adult day care, personal care, nursing care, etc.) on the same day as he/she receives temporary residential care. Payment may not be made for temporary residential furnished at the same time when other provided services include care and supervision.

Staff Requirements

All direct-care staff must be 18 years of age and have a high school diploma or its equivalent.*

*Exemptions to HS diploma/GED requirement:

- + Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be “grandfathered.”
- + Staff without diplomas or GEDs may be employed for up to one year while the person works to attain the requirement. The provider must document the staff’s enrollment in school or GED courses.
- + After July 1, 1996, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional office agreement in the employee’s file.

All direct-care staff shall have training that covers at a minimum:

- Training, procedures and expectations related to this service in regards to following and implementing the individual’s support plan. Training in implementation of each individual’s current support plan/addendums shall be completed within one month of the implementation date of the current plan, or within one month of employment for new staff.
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support.
- Have current certification in competency-based CPR and First Aid courses.
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070.
- Training in positive behavior support curriculum approved by the Division of DD (within three months of employment).

Billing Information: Temporary Residential

Medicaid procedure code–



- Temporary Residential: H0045
 - Unit of Service: One (1) Day
 - Maximum Units of Service: 1/day
- Out of Home Respite: H0045
 - Unit of Service: 15 minutes
 - Maximum Units of Service: 95/day (Note: 15 minute units are billed for dates the service is delivered on a less than 24 hour basis)

Temporary Residential Service Documentation

Providers of the temporary residential service must maintain attendance records and progress notes. The provider is required to follow procedures as set forth in Section C of this manual.

Transportation

Available in All Waivers

Service Description

Transportation is reimbursable when necessary for an individual to access waiver and other community services, activities and resources specified by the ISP plan. Transportation under the waiver shall not supplant transportation provided to providers of medical services under the state plan as required by 42 CFR 431.53, nor shall it replace emergency medical transportation as defined at 42 CFR 440.170(a) and provided under the state plan. State plan transportation in Missouri is provided to medical services covered under the state plan, but not to waived services, which are not covered under the state plan. Transportation is a cost effective and necessary part of the package of community services, which prevent institutionalization.

A variety of modes of transportation may be provided, depending on the needs of the individual and availability of services. Alternatives to formal paid support will always be used whenever possible. A unit is one per month.

State plan transportation under this waiver is limited to medical services covered in the state plan. State plan transportation does not cover transporting persons to waiver services, which are not covered under the state plan.

Provider Requirements

A transportation provider must be licensed per RSMo Chapter 302, Drivers and Commercial Licensing, and have a DMH contract.

Billing Information: Transportation

Medicaid procedure code–

- Transportation: A0120
 - Unit of Service: Month
 - Maximum Units of Service: 1/Month

Transportation Service Documentation



Transportation providers must maintain service documentation as described in Section C of this manual.

- Individual trip records for each individual transported;
- Mileage or zone records of miles or zones provided; and
- Accurate records of transportation costs.

Section G: Waiver Assurances

MO Division of DD Quality Management

Quality management is an ongoing process states must implement to ensure a waiver program operates as designed, meets statutory and regulatory assurances and requirements, meets intended outcomes, and identifies enhancement opportunities. The six areas of waiver assurance are:

- **Level of Care (LOC) Determination**
- **Individual Support Plans**
- **Qualified Providers**
- **Health and Welfare**
- **Administrative Authority**
- **Financial Oversight**

For each of the six areas, the State was required to describe in its quality management strategy, activities or, processes related to discovery (monitoring and recording the findings); the entities or individuals responsible for conducting the discovery/monitoring processes; the types of information used to measure performance; and the frequency with which performance is measured. Additional detailed descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery were described through the approved waiver application, although they may not be specifically identified in this summary. The following sections include CMS required assurances (bold/italics) and an abbreviated statement of processes the Division of DD has identified to address each component of the six waiver quality management assurances.

Level of Care Determination

Waiver individuals for whom there is reasonable indication that services may be needed in the future are provided an individual level of care evaluation.

Enrolled individuals are reevaluated at least annually or as needed.

The process and instruments described in the approved waiver are applied to level of care determinations.

The state monitors level of care decisions and takes action to address inappropriate level of care determinations.



Individual Support Plans

ISPs address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

The State monitors ISP development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of plans of care.

ISPs are updated and revised when warranted by changes in waiver individual needs.

Services are specified by type, amount, duration, scope and frequency and are delivered in accordance with the ISP.

Individuals are afforded choice between waiver services and institutional care. Individuals are afforded choice between/among waiver services and provider.

Qualified Providers

The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

The State identifies and rectifies situations where providers do not meet requirements.

The State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.

Division of DD monitors providers to assure they meet qualifications.

Health and Welfare Assurance

There is continuous monitoring of health and welfare of waiver individuals and remediation actions are initiated when appropriate.

On an ongoing basis the State identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Administrative Authority

The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.

- **DSS retains final approval authority for all decisions made by the operating agency including determinations, policies and procedures. Division of DD as the operating agency implements day to day oversight of operation of the waiver.**



- DSS/Division of DD audits records of sample individuals annually. This includes a comprehensive compliance review of assurances the state has made. In addition, the MMAC Unit conducts a financial review of payments made to waiver providers.
- The Division of DD Federal Programs Unit works with the Quality Enhancement Leadership Team and Regional offices to address issues identified, including training targeted to address trends locally or statewide as appropriate.
- Division of DD monitors other TCM entities that provide TCM that supports waiver individuals for compliance with State and Federal laws and regulations, conditions of participation, and assurances. Direct services provided by other TCM entities are subject to the same standards and provisions as other providers.

Financial Accountability Assurance

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

- MMAC Unit contacts providers that billed services for the individuals and requests that documentation of delivered services be provided for review.
- UR Committees review all initial ISP and budgets (and those with increased funding requests) to ensure individuals' needs are being addressed and that levels of funding for individuals with similar needs are similar statewide.