

STATE OF MISSOURI



DEVELOPMENTAL
DISABILITIES WAIVERS
MANUAL



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Developmental Disabilities Waivers Manual **Comprehensive, Community Support, MOCDD (otherwise known as the Sarah 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 four Medicaid Home and Community-Based Services (HCBS) Waiver programs for individuals with developmental disabilities. The four waivers are the Comprehensive Waiver; Missouri Children with Developmental Disabilities Waiver (MOCDD or Lopez Waiver); Community Support Waiver; and Partnership for Hope Waiver (PfH).

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 (HCB) waivers, a state may use Medicaid funding for HCBS 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.

Acronyms

ABA	Applied Behavior Analysis
ACRE	Association of Community Rehabilitation Educators
ADL	Activities of Daily Living
ALF	Assisted Living facilities
AOTA	American Occupational Therapy Association
APSE	Association of People Supporting Employment First
ASD	Autism Spectrum Disorder
BCBA	Board Certified Behavior Analyst
BSHCN	Bureau of Special Health Care Needs
BSP	Behavior Support Plan
BP	Benefits Planning
CARF	Commission on Accreditation of Rehabilitation Facilities
CESP	Certified Employment Support Professional
CFR	Code of Federal Regulations
CN	Community Networking
CS	Community Specialist
CIMOR	Customer Information Management, Outcomes & Reporting
CI	Crisis Intervention
CIT	Crisis Intervention Training
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nursing Assistant
COTA	Certified Occupational Therapeutic Assistant
CPR	Cardiopulmonary Resuscitation
CPTA	Certified Physical Therapeutic Assistant
CQL	Council on Quality and Leadership/The Council



CSR	Code of State Regulations
DD	Developmental Disabilities
DH	Day Habilitation
DHSS	Department of Health and Senior Services
DOL	Department of Labor
DR	Designated Representative
DME	Durable Medical Equipment
DMH	Department of Mental Health
DSDS	Division of Senior and Disability Services
DSS	Department of Social Services
EAA	Environmental Accessibility Adaptations
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
ESPCC	Employment Support Professional Certification Council
FBA	Functional Behavior Assessment
F/EA	Fiscal/Employer Agent
FFP	Federal Financial Participation
FMS	Fiscal Management Service
FSD	Family Support Division
FSP	Family Support Partner
GED	General Education Development
HAC	Health Assessment and Coordination Services
HCB	Home and Community-Based
HCBS	Home and Community-Based Services
HDM	Home Delivered Meals
HIPAA	Health Insurance Portability and Accountability Act
HS	High School
IDS	Individual Directed Goods and Services
I&A	Information and Assistance
IADL	Instrumental Activities of Daily Living
ICF/IDD	Intermediate Care Facility/Intellectual and Developmental Disabilities
I/DD	Intellectual/Developmental Disability
IRS	Internal Revenue Service
ISD	Individualized Skill Development
ISL	Individualized Supported Living
ISP	Individual Support Plan
ITRH	Intensive Therapeutic Residential Habilitation
LaBA	Licensed Assistant Behavior Analyst
LBA	Licensed Behavior Analyst
LOC	Level of Care
LPN	Licensed Practical Nurse
MMAC	Missouri Medicaid Audit and Compliance Unit
MO	Missouri
MOCABI	Missouri Critical Adaptive Behavior Inventory
MOCDD	Missouri Children with Developmental Disabilities Waiver (or Lopez Waiver)
MRS	Medication Reminder Systems
NADSP	National Alliance for Direct Support Professionals



NCI	Nonviolent Crisis Intervention
OHCDS	Organized Health Care Delivery System
OT	Occupational Therapy/Occupational Therapist
PA	Personal Assistant
PAM	Professional Assessment and Monitoring
PCA	Personal Care Assistance
PCSC	Person Centered Strategies Consultation
PERS	Personal Emergency Response Systems
PfH	Partnership for Hope Waiver
PIC	PERS Client's Medical Identification Code
PON	Prioritization of Need/Priority of Need
POS	Purchase of Service
PT	Physical Therapy/Physical Therapist
QHCP	Qualified Health Care Professional
RBT	Registered Behavior Technician
RCF	Residential Care Facility
RN	Registered Nurse
RSMo	Revised Statutes of Missouri
SB 40	Senate Bill 40 Board
SDS	Self-Direct Services/Self-Directed Supports
SIL	Semi-Independent Living
SLP	Speech-Language Pathologist
SME	Specialized Medical Equipment and Supplies
ST	Speech Therapy/Speech Therapist
TCM	Targeted Case Management
UAP	Unlicensed Assistive Personnel
VR	Vocational Rehabilitation

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 (LOC) requires the presence of developmental disabilities (DD) as defined in federal rule (42 CFR 435.1010) as an Intellectual Disability or related condition as described below:

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 DD 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 LOC 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, unless services are allowable as described in the service definitions section of this manual and is not a substitute for services that the nursing home, ICF/IDD or hospital are obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement.

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 (LOC) and Eligibility for the Developmental Disabilities Waivers

Before a person enters the DD 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 LOC or individual planning is requested. The support coordinator then completes a functional screening instrument designed to provide general information on what a person with DD can and cannot do and lists any types of adaptations and supports which are in use.

The Division uses standard tools to determine level of functioning. Assessment specified in Chapter 2 of 9CSR-45 such as the MOCABI and Vineland are the typical tests of adaptive behavior for all waiver participants. Other formal normative based, standardized assessments of adaptive function may be used to supplement or replace the MOCABI and Vineland. In addition, educational, psychological and medical records, etc. may be used to assist in documenting the individual's diagnosis and level of functioning. These other standardized assessments will not impact eligibility, and current waiver participants will not lose eligibility or services based on these assessments. Any standardized assessment tool utilized will not make it more difficult for an applicant to become waiver eligible. Rather, the tool streamlines the process for applicants, by reducing several different assessments into a single tool. 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 LOC Form:

- That the individual has DD and/or a disability that meets the federal definition of a “related condition;”
- That the individual has limitations, which if not for HCB 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 LOC for the DD waivers. All LOC 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 DD waivers, which includes continued need for an ICF/IDD LOC. 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. As part of annual planning, LOC determinations must be completed within 90 days prior to the Individual Support Plan (ISP) implementation date. LOC implementation date will be effective with the ISP implementation date.

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 ISP, also known as the service 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 Home and Community Based Services (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 support 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 individual and/or his or her representative, the support coordinator, and the service provider. 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 DD 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 Unit, 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.

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. Settings in which individuals are receiving Medicaid HCBS waiver services must be compliant with the HCBS settings criteria. If Medicaid is only funding non-residential HCBS waiver services for an individual, the state is not responsible for ensuring compliance with the settings criteria for the setting where the individual resides. Waiver services for DD waiver individuals living in a residential care or assisted



living facility (ALF) may not duplicate or supplant State Plan services and is limited to assisting the waiver individual while they are out in the community.

Medicaid Waiver, Provider, and Services Choice Statement

When it is determined that a person needs the LOC 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 DD 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 DD 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 DD waiver services.

When more than one provider of service is enrolled as a DD waiver provider for a particular geographic area, the individual and legal guardian must be given a choice among those providers. The Support Coordinator educates and informs individuals regarding eligible providers of services to the individual or guardian during the annual planning process and at any time as needed. The Medicaid Waiver, Provider, and Services Choice Statement is used in conjunction with educating and informing individuals of eligible providers for documentation of provider choice. Documentation of education and choice of providers must be included in the annual plan. Attached to the choice statement is the list of eligible providers for the given service. 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 DD 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 DMH and Department of Social Services (DSS), MO HealthNet Division. While not required to do so, individuals are encouraged to begin with the DMH's appeal process. The DMH 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 DMH process. Once the individual begins the appeal process with the DSS, all appeal rights with the DMH end since any decision by the single State Medicaid Agency would supersede a decision by DMH.

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 LOC.

Community Support Waiver

To be eligible for the Community 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 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 LOC; and
- Have needs that can be met within the waiver cap of \$40,000.



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;
- Have a need for a waiver service;
- Be screened and determined not eligible for MO HealthNet for Kids and MO HealthNet for Disabled Children;
- Require an ICF/IDD LOC and be at risk of entering an ICF/IDD facility if not provided services under the waiver; and
- Be determined by the regional office initially and annually thereafter to require an ICF/IDD LOC.

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 LOC 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.

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 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 \$12,362 annually; and
- Be determined by the regional office initially and annually thereafter to require an ICF/IDD LOC.

Prioritization of Need

Access to waivers is based on prioritization of need (PON). The Comprehensive, Community Support 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 (PON). 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 Senate Bill 40 Board (SB 40) 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 (3) 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 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 Community Support Waiver has an annual cost cap of \$40,000; and
- The PfH Waiver has an annual individual cost cap of \$12,362 or less, or up to \$15,000 if the individual meets criteria. 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 for recommendation of 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 is required in these DD waiver services; Day Habilitation (DH), Individualized Skill Development (ISD), Community Integration (CI), Group Home, Individualized Supported Living (ISL), Out of Home Respite, Personal Assistance, any Employment related service and Shared Living.

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).

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 ISL and at least quarterly for individuals who live in their natural home.

As per [13 CSR 70 – 3.030](#), 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 HealthNet programs and services that are reimbursed according to the amount of time spent in delivering the service, such as PA. (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

SDS is an option for individuals who live in a private residence. SDS enables individuals with DD 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 (DR) has employment and budget authority.



[9 CSR 45-3.080 Self-Directed Supports](#) establishes the scope of and requirements for the use of SDS, a service delivery option available under Home and Community Based waivers as created by section 1915(c) of the Social Security Act.

- Employment authority allows the individual or his/her DR to recruit, hire, train, manage, supervise and fire employees;
- Budget Authority allows the individual or his/her DR 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 state minimum wage and approved Medicaid 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 DR 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 in section [9 CSR 45-2.020 Appeals Procedures for Service Eligibility through the Division of DD](#).

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 UR 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 UR process, which is in state regulation, are available to the public from the State's web site in [9 CSR 45-2.017 Utilization Review Process](#).

Services are prior authorized on a yearly basis based on the needs of the individual. Individuals/guardians and DRs 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 four DD waivers:

- Community Specialist (CS)
- Personal Assistant (PA)
- Medical Personal Assistant
- Team Collaboration
- Individual Directed Goods and Services (IDS)

The support coordinator will assist the individual or his/her DR in understanding the choice of SDS and transitioning from provider driven to SDS. Support Broker services provide information and assistance (I&A) 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 personal care assistance (PCA) self-directed (Consumer Directed Services) or DD waiver 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 DR. The DR is responsible for managing 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 DR *must*:

- 1) Direct and control the employees' day to day activities;
- 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 DR are required to:

- Comply with the 21st Century CURES Act and 13 CSR 70-3.320 which requires the use of an electronic visit verification (EVV) system to capture data points for the delivery of in-home services for self-directed PA services.
- 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 and documentation of required training has been received before hiring him or her and allowing them to do any work for you;
- Hire employees;
- After hire, train employees based on the ISP and FMS employee training handbook;
- Establish a work schedule for employees;
- Manage employees;
- 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 (DOL) 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 (HS) diploma or general education development (GED) certificate;
- Create and maintain an emergency back-up plan in the event that an employee does not show up for work and who to contact for any emergency.

Service Documentation Maintained

All services provided *must* be adequately documented and signed by the person providing the direct 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 for a period of six years;
- Documentation to support the service is required to be documented by the staff providing it within a contemporaneous timeframe. Contemporaneous means at the time the service was performed or within five (5) business days, of the time the service was provided;
- Documentation *must* be signed by the employee providing the service.

The Division of DD contracts with a single Vendor Fiscal/Employer Agent (F/EA) 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 Internal Revenue Service (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. Beginning in February 2016, the FMS maintains Service documentation for a period of 6 years for the individual and/or a DR.

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. The SDS individual budget allocation shall be based on the total number of hours needed for the span dates of the ISP multiplied by the statewide base rate for comparable agency-based supports.
- The budget and ISP are reviewed by the 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 DMH and DSS. While individuals are encouraged to begin with the DMH'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 DRs 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 DRs served by the Division of DD and providers are provided information on the UR process.

If an individual voluntarily requests to terminate SDS 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 DR's willingness to ensure employee records are accurately kept, or if the individual/guardian or DR 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 DR 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.

Immediate Termination for Non- Compliance. When there is evidence of fraud or repeated patterns or trends of non-compliance with program requirements, counseling has been provided to the employer, an improvement plan has been established but has not been successfully completed within the agreed upon time frames, the regional director shall immediately terminate SDS and shall authorize agency-based services from a provider agency chosen by the individual. The regional office shall request repayment from the employer for any recoupments by the MMAC office from the Division of DD.

Section E: Organized Health Care Delivery System

Waiver services may be provided by an 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;
- All subcontractors *must* agree to maintain service documentation and make it available to the OHCDS or MO HealthNet upon request.

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

Applied Behavior Analysis

Available in all Waivers

Service Description

The state plan includes coverage for ABA services for children (under age 21) who have a diagnosis of Autism Spectrum Disorder (ASD). The Waivers include coverage for ABA services for children without a diagnosis of ASD and adults.

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

Central to the implementation of appropriate ABA services is the Behavior Support Plan (BSP), which is a treatment plan that involves the following elements:

- The BSP should describe strategies and procedures to generalize and maintain the effects of the BSP and to collect data to assess the effectiveness of the plan and fidelity of implementation of the plan.
- The specific skills and behaviors targeted for each individual should be clearly defined in observable terms and measured carefully by direct observation each session.
- The BSP shall include: collection of data by the staff, family and or caregivers that are the primary implementers of the plan; 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 ISP, which *must* include separate, measurable goals and objectives with clear definitions of what constitutes mastery.

- Reports regarding the service *must* include data displayed in graphic format with relevant environmental variables that might affect the target behaviors indicated on the graph. The graph should provide indication of analysis via inclusion of environmental variables including medications and changes in medications, baseline or pre- intervention levels of behavior and strategy changes.
- Performance-based training for parents, caregivers and significant others in the person's life is also part of the behavior analysis services if these people are integral to the implementation or monitoring of the plan.

ABA services consist of the following components:

There are two primary types of ABA services: "Assessment services" analyze the situation and lead to recommendations (described in the "BSP") for how to address the issues; and "Adaptive Behavior Treatment services" which are made up of several different methods of treatment, most of which could be used alone, but far more frequently are used in various combinations.

Assessment Services

A "descriptive assessment" (called Functional Behavior Assessment (FBA)) comprised of at least Behavior Identification Assessment and Observational Behavioral Follow-Up Assessment.

- Behavior Identification Assessment; and
- Observational Behavior Follow-up Assessment; and possibly
- Behavior Identification Supporting Assessment (service previously titled Exposure Behavioral Follow-up Assessment.)

Adaptive Behavior Treatment (services previously titled Senior Consultant and Behavior Intervention Specialist):

- Adaptive Behavior Treatment with Protocol Modification (could be a stand-alone service if that was the recommendation of the assessment, but likely are used in combination with one of the below);
- Adaptive Behavior Treatment by Protocol by Technician;
- Exposure Adaptive Behavior Treatment with Protocol Modification;

The services below would *not* be a stand-alone service, but might be used in conjunction with the services above:

- Family Adaptive Behavior Treatment Guidance (service previously titled Family Behavior Treatment Guidance.);
- Adaptive Behavior Treatment Social Skills Group (service previously titled Behavior Treatment Social Skills Group).

Assessment: ABA services are based on an assessment which identifies functional relationships between behavior and the environment, including contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical

variables related to challenging behaviors or situations. The assessment is further composed of the following elements:

- **Behavior Identification Assessment:** This assessment is completed by the physician or other Qualified Health Care Professional (QHCP), face-to-face with patient and caregiver(s) and include: administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.
- **Behavior Identification Supporting Assessment-Observational:** The observational assessment may be required to finalize or fine-tune the baseline results and plan of care that were initiated in the identification assessment. This service is performed by a technician under the direction of a QHCP or Licensed Assistant Behavior Analyst (LaBA). The QHCP or LaBA may or may not be on-site during the face-to-face assessment process. This assessment is provided to individuals who present with specific destructive behavior(s) (e.g., self-injurious behavior, aggression, property destruction) or behaviors or deficits in communication or social relatedness. Observational Follow-up includes the use of structured observation and/or standardized and non-standardized tests to determine levels of adaptive behavior. Areas assessed may include cooperation, motivation, visual understanding, receptive and expressive language, imitation, requests, labeling, play and leisure and social interactions. Specific destructive behavior(s) assessments include structured observational testing to examine events, cues, responses, and consequences associated with the behavior(s).
- **Behavior Identification Supporting Assessment-Exposure** (service previously titled Exposure Behavioral Follow-up Assessment): This Exposure Assessment is administered by the QHCP with the assistance of one or more technicians. This assessment includes the QHCP's interpretation of results, discussion of findings and recommendations with primary caregiver(s), and preparation of report. Typical individuals for these services include those with more specific severe destructive behavior(s) (e.g., self-injurious behavior, aggression, property destruction). Specific severe destructive behavior(s) are assessed using structured testing to examine events, cues, responses, and consequences associated with the behavior. This assessment includes exposing the individual to a series of social and environmental conditions associated with the destructive behavior(s). Assessment methods include using testing methods designed to examine triggers, events, cues, responses, and consequences associated with the before mentioned maladaptive behavior(s). This assessment must be completed in a structured environment to ensure safety.

Adaptive Behavior Treatment: Adaptive Behavior Treatment addresses the individual's specific target problems and treatment goals as defined in previous assessments. Adaptive behavior treatment is based on principles including: analysis and alteration of contextual events and motivating factors, stimulus-consequence strategies, replacement behavior, and monitoring of outcomes. Goals of adaptive behavior treatment may include reduction of repetitive and aberrant behavior, improved communication, and social functioning. Adaptive behavior skill tasks are often broken down into small, measurable units, and each skill is practiced repeatedly until mastered. Adaptive Behavior Treatment may occur in multiple sites and social settings (e.g., controlled treatment programs with individual alone or in a group setting, home, or other natural environment). All ABA services are considered short-term services whose objectives are to provide changes in patterns of interactions, daily activities and lifestyle including provider family/staff/caregivers skills to teach the individuals



adaptive skills and skills that address problem behaviors. The development of skills in the individual and in the family/staff/caregivers is a key component to these services. In addition, it is the essential that the strategies developed are adapted to more typical types of support strategies so that the BSP is replaced with these more typical strategies as the service is successful.

Adaptive behavior treatment is further composed of the following elements:

- **Adaptive Behavior Treatment by Protocol by Technician:** This treatment is administered by a single technician or LaBA under the direction (on-site or off-site) of the QHCP by adhering to the protocols that have been designed by the QHCP. This service is delivered to the individual alone or while attending a group session. This includes skill training delivered to an individual who, for example, has poor emotional responses (e.g., rage with foul language and screaming) to deviations in rigid routines. The technician introduces small, incremental changes to the individual's expected routine along one or more stimulus dimension(s), and a reinforcer is delivered each time the individuals appropriately tolerates a given stimulus change until the individual tolerates typical variations in daily activities.

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

- **Adaptive Behavior Treatment with Protocol Modification:** This treatment is administered by a QHCP or LaBA who is face-to-face with a single individual. The service may include demonstration of the new or modified protocol to a technician, guardian(s), and/or caregiver. For example, Adaptive Behavior Treatment with Protocol Modification will include treatment services provided to a teenager who is recently placed with a foster family for the first time and is experiencing a regression of the behavioral targets which were successfully met in the group-home setting related to the individual's atypical sleeping patterns. The clinical social worker modifies the past protocol targeted for desired results to incorporate changes in the context and environment. A modified treatment protocol is administered by the QHCP to demonstrate to the new caregiver how to apply the protocol(s) to facilitate the desired sleeping patterns to prevent sleep deprivation.
- **Exposure Adaptive Behavior Treatment with Protocol Modification:** This treatment is provided to individuals with one or more specific severe destructive behaviors (e.g., self-injurious behavior, aggression, property destruction), with direct supervision by a QHCP which requires two or more technicians face-to-face with the individual for safe treatment. Technicians elicit behavioral effects of exposing the individual to specific environmental conditions and treatments. Technicians record all occurrences of targeted behaviors. The QHCP reviews and analyzes data and refines the therapy using single-case designs; ineffective components are modified or replaced until discharge goals are achieved (e.g., reducing destructive behaviors by at least 90%, generalizing the treatment effects across caregivers and settings, or maintaining the treatment effects over time). The treatment is conducted in a structured, safe environment. Precautions may include environmental modifications and/or protective equipment for the safety of the individual or the technicians. Often these services are provided in intensive out patient, day treatment, or inpatient facilities, depending on the dangerousness of the behavior.



- **Family Adaptive Behavior Treatment Guidance:** This treatment guidance is administered by a QHCP or LaBA face-to-face with family/guardian(s)/caregiver(s) and involves teaching family/guardian (s)/caregiver(s) to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits.
- **Adaptive Behavior Treatment Social Skills Group** (previously titled Behavior Treatment Social Skills Group): This treatment social skills group is administered by a QHCP or LaBA face-to-face with multiple individuals, focusing on social skills training and identifying and targeting individual patient social deficits and problem behaviors. The QHCP or LaBA monitors the needs of individuals and adjusts the therapeutic techniques during the group, as needed. Services to increase target social skills may include modeling, rehearsing, corrective feedback, and homework assignments. In contrast to adaptive behavior treatment by protocol techniques, adjustments are made in real time rather than for subsequent services.

When providing Behavior Identification Assessment, Observational Behavioral Follow-Up Assessment, Behavior Identification Supporting Assessment, Adaptive Behavior Treatment with Protocol Modification, Family Adaptive Behavior Treatment Guidance, and Adaptive Behavior Treatment Social Skills Group services via telehealth, please refer to Section G: Telehealth Services in this manual for additional requirements.

For individuals hospitalized, ABA services may be provided to assist with supports, supervision, communication, and any other supports that the hospital is unable to provide and does not substitute for a service the hospital is obligated to provide. The service will: be identified in an individual's person-centered service plan; provided to meet needs of the individual that are not met through the provision of hospital services; not substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and be designed to ensure smooth transitions between acute care settings and HCB settings, and to preserve the individual's functional abilities.

Service Limitations

This service is limited to additional services not otherwise covered under the state plan, including Early Periodic Screening, Diagnosis and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

<p>Limitations of the Behavior Identification Assessment A unit is 15 minutes. Limited to 8 units per year.</p>
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<p>Limitations of the Behavior Identification Supporting Assessment-Observational: A unit is 15 minutes. Limited to 10 units per day, 50 units per week, and 50 units per year. All Behavior Identification Supporting Assessments-Observational <i>must</i> be administered by the Registered Behavior Technician (RBT) under the direction of the QHCP that is a Licensed Behavior Analyst (LBA), or under the direction of a LaBA; the service can also be done by the QHCP or LaBA.</p>
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<p>Limitations of the Behavior Identification Supporting Assessment-Exposure: A unit is 15 minutes. Limited to 32 units per day and 100 units per year. Behavior Identification Supporting Assessment-Exposure <i>must</i> receive prior approval by the DMH, Division of DD Chief Behavior Analyst. Behavioral Identification Supporting Assessment can be done by the RBT under the direction of the QHCP that is a LBA, or under the direction of a LaBA; the service can also be done by the QHCP or LaBA.</p>



<p>Limitations of Adaptive Behavior Treatment by Protocol by Technician: A unit is 15 minutes. Limited to 32 units per day, 160 units per week, and 600 units per month. All Adaptive Behavior by Protocol by Technician <i>must</i> be performed by a RBT or LaBA under the direction of a QHCP that is a LBA. This service <i>must</i> be provided concurrent with Adaptive Behavior Treatment with Protocol Modification by a LBA for at least the equivalent of 5% of the total units provided by the RBT.</p>
<p>Limitations for Adaptive Behavior Treatment with Protocol Modification A unit is 15 minutes. Limited to 32 units per day, 120 units per week, and 270 units per month. Extensions may be approved by the Division of DD Chief Behavior Analyst, or designee. Ten percent (10%) of units authorized in a plan year for this service would be appropriately utilized for indirect services such as protocol modification and data analysis. This would require documentation (as with all other units) in addition to the written modified protocol and graphic display, with current data and progress report describing the analysis and effects on intervention strategies related to the analysis.</p>
<p>Limitations of Exposure Adaptive Behavior Treatment with Protocol Modification: A unit is 15 minutes. Limited to 34 units per day, 130 units per week, and 320 units per month. Exposure Adaptive Behavior Treatment with Protocol Modification <i>must</i> receive prior approval by the DMH, DD Chief Behavior Analyst. Ten percent (10%) of units authorized in a plan year for this service would be appropriately utilized for indirect services such as protocol modification and data analysis. This would require documentation (as with all other units) in addition to the written modified protocol and graphic display, with current data and progress report describing the analysis and effects on intervention strategies related to the analysis.</p>
<p>Limitations of Family Adaptive Behavior Treatment Guidance: A unit is 15 minutes: and 40 units per month. In addition, no more than 8 family members/guardians/caregivers can be present for a unit to be billed. This service can be concurrent to any of the other treatment services.</p>
<p>Limitations of Adaptive Behavior Treatment Social Skills Group: A unit is 15 minutes: 6 units per day, 30 units per week, and 60 units per month. In addition, no more than 8 individuals can be present for a unit to be billed. This service can be concurrent to any of the other treatment services.</p>

Provider Requirements

As identified in the definition above, services can be provided by a QHCP, a LaBA under the supervision of a QHCP who is an LBA, or an RBT under the supervision of a QHCP who is an LBA.

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

A QHCP must have a graduate degree and MO State license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis (RSMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224).

An LaBA must have MO State license as an assistant Behavior Analyst (RSMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224).

The RBT must be registered with the Behavior Analyst Certification Board



ABA services can be provided by a person enrolled in a graduate program for ABA and completing the experience requirements with ongoing supervision by a LBA in the state of MO who is a contracted provider for the Division. These services provided by a person as part of the experience requirement and under the supervision of the LBA will be considered as the equivalent of LaBA services for purposes of billing and eligibility to provide particular ABA services.

Billing Information: Applied Behavior Analysis

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Behavior Identification Assessment	97151	15 minutes	8 units per year
Observational Behavioral Follow-Up Assessment	97152 HO 97152 HM 97152 HN	15 minutes	10 units per day, 50 units per week, 50 units per year
Behavior Identification Supporting Assessment	0362T	15 minutes	32 units per day, 100 units per year
Adaptive Behavior Treatment with Protocol Modification	97155 HO 97155 HN	15 minutes	32 units per day, 120 units per week, 270 units per month
Exposure Adaptive Behavior Treatment with Protocol Modification	0373T	15 minutes	34 units per day, 130 per week, 320 units per month
Adaptive Behavior Treatment by Protocol by Technician	97153 HM 97153 HN	15 minutes	32 units per day, 160 units per week, 600 units per month
Family Adaptive Behavior Treatment Guidance	97156 HO 97156 HN	15 minutes	40 units per month
Adaptive Behavior Treatment Social Skills Group	97158 HO 97158 HN	15 minutes	6 units per day, 30 units per week, 60 units per month
Hospital Supports for all ABA services is by Place of Service "21"		15 minutes	See specific ABA service code above for limitations.

Applied Behavior Analysis Service Documentation

The provider must maintain service documentation as per the requirements set forth 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 BSP. Progress notes should be written at least monthly and include data regarding program fidelity, any concerns from QHCP or other members of planning team, and data with respect to implementation effects. The progress notes should also include summary of contacts made by family, caregivers, etc., and any actions taken and modifications made to the BSP. Graphic presentation of data and interpretation of the data shall be included in the progress notes submitted to the planning team and support coordinator. The FBA *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 BSP, graphic data, and progress notes from the period the service is provided must be included with the written individual plan of care upon termination of services. This information will be filed in the individual's chart, located in the Regional Office or with the TCM entity with whom the individual is enrolled.

Assistive Technology
Available in all Waivers

Service Description

“Assistive technology” means a device, product system, or engineered solution whether acquired commercially, modified, or customized that addresses an individual's needs and outcomes identified in his or her individual service plan. The service is for the direct benefit of the individual in maintaining or improving independence, functional capabilities, vocational skills, or community involvement. Remote monitoring will assist the individual to fully integrate into the community, participate in community activities, and avoid isolation.

The individual's person-centered planning team will ensure that the individual understands the use of technology, the individual/family has information needed in order to make an informed choice/consent about remote monitoring versus an in-person support staff service, and that he/she understands privacy protections as documented in the approved ISP. The Support Coordinator and providers will share responsibility for monitoring privacy concerns. The ISP documents all back-up support plans based on the individual's needs. The ISP will document who is responsible for the monitoring activity and if they are on-site or off-site.

Remote supports promotes individuals building self-determination, self-reliance, independence and confidence which decreases their reliance on paid staff for activities in the home and community.

Assistive technology must include at least one of the following components:

- (a) “Assistive technology consultation” means an evaluation of the assistive technology needs of an individual, including a functional evaluation of technologies available to address the individual's assessed needs and support the individual to achieve outcomes identified in his or her individual service plan.
- (b) “Assistive technology equipment” means the cost of leasing, purchasing, warranty at purchase or otherwise providing for the acquisition of equipment and may include engineering, designing, fitting, customizing, or otherwise adapting the equipment to meet an individual's specific needs. Assistive technology equipment may include Personal Emergency Response Systems (PERS), Mobile Emergency Response Systems (MERS), Medication Reminder Systems (MRS) and equipment used for remote support such as motion sensing system, radio frequency identification, live video feed, live audio feed, or web-based monitoring. Assistive technology cannot be accessed to purchase video monitors or cameras to be placed in bedrooms and bathrooms. Remote monitoring and placement of cameras in bedrooms and bathrooms is not allowed.
- (c) “Assistive technology service delivery” means monthly implementation of service and monitoring of the technology equipment and individual as necessary. Monitoring may include the response center for PERS, MERS, or remote support.



- (d) “Assistive technology support” is intended for education and training beyond that included in initial installation/training and routine service delivery questions and implementation that aids an individual in the use of assistive technology equipment as well as training for the individual's family members, guardians, staff, or other persons who provide natural supports or paid services, employ the individual, or who are otherwise substantially involved in activities being supported by the assistive technology equipment. Assistive technology support may include, when necessary, coordination with complementary therapies or interventions and adjustments to existing assistive technology to ensure its ongoing effectiveness.

Assistive technology shall *not* include household appliances or items that are intended for purely diversional or recreational purposes. Assistive technology should be evidenced based, and shall *not* be experimental.

Electronic support systems using on demand video and/or web-cameras, or other technology is only available on an individual, case-by-case basis when an individual requests the service and the planning team agrees it is appropriate and meets the health and safety needs of the individual. Video and/or web-cameras shall *not* record an individual’s activities. Remote support technology may only be used with full consent of the individual and his/her guardian and with a completed review by a DMH approved due process committee to ensure the individual’s rights are being protected.

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

The type of equipment and where placed will depend upon the needs and wishes of the individual and their guardian (if applicable), and will also depend upon the particular company selected by the individual or guardian to provide the equipment. The installation of video 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 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 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, participant medical issue or personal emergency in place and detailed in writing for each site utilizing the system as well as in each participant’s ISP. The ISP must specify the individuals to be contacted by monitoring base staff who will be responsible for responding to these situations and traveling to the 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 staff should call 911.

Waiver individuals interested in electronic support technology must be assessed for risk following the division’s risk assessment guidelines, and must be provided information to ensure an informed choice about the use of equipment versus in-person support staff.

Service Limitations



Assistive technology equipment does not include items otherwise available as environmental accessibility adaptations (EAA) or specialized medical equipment and supplies.

Assistive technology consultation is limited to one per year. An exception may be extended if the participant is pursuing a new or additional type of technology in the same year.

Assistive technology support is limited to 40 hours per year.

An individual cannot receive the MERS and the PERS service at the same time.

The costs of all components of Assistive Technology equipment shall *not* exceed \$9,000 per annual support plan year, per individual.

Exceptions are allowed to the \$9,000 annual spending limit for assistive technology with regional director or designee approval. If a person's need can't be met within a limit, attempts will be made to locate another funding source or an exception may be approved by the by the director or designee to exceed the limit if exceeding the limit will result in decreased need (units) of one or more other services. The service plan must document exceeding the limit for the service that will result in a decreased need of one or more other services. If it is determined the needs of a significant number of individuals cannot be met within the limitation, an amendment will be requested to increase the amount of the limitation.

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.

Remote monitoring will meet HIPAA requirements and the methodology will be accepted by the state's HIPAA compliance officer.

Other Standards

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.

The consultation component may be provided by a person with a MO license in occupational therapy (OT), physical therapy (PT), speech-language pathology (SLP), or an Assistive technology professional certification issued by the "Rehabilitation Engineering and Assistive Technology Society of North America," a Bachelor's degree and a certificate from a nationally recognized



assistive technology assessment curriculum or a Bachelor's degree considered a specific technology expert as employed by the technology specific provider for at least one year.

Procedure code A9999 will have an internal Customer Information Management, Outcomes & Reporting (CIMOR) modifier "GT" for Remote Supports, PERS and MERS services.

Billing Information: Assistive Technology

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Assistive Technology	A9999	1 job or item	1 per month/\$9,000 per annual support plan year
Remote Supports and Personal Emergency Response System	A9999 GT	1 job or item	
Assistive Technology/AT Consultation	A9999 UA	1 job or item	
Assistive Technology/AT Equipment	A9999 UB	1 job or item	
Assistive Technology/AT Service Delivery	A9999 UC	1 job or item	
Assistive Technology/AT Support	A9999 U9	1 job or item	

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.

Benefits Planning

Available in Comprehensive, Community Support and PFH Waivers only

Service Description

BP is a service designed to inform an individual about competitive integrated employment and assist them to assess if it will result in increased economic self-sufficiency and/or net financial benefit through the use of various work incentives. This service provides information to the participant regarding the full array of available work incentives for essential benefit programs including Supplemental Security Income, SSDI, Medicaid, Medicare, housing subsidies, food stamps, ABLE accounts, etc.

The service also will provide information, education, consultation and technical assistance to the individual regarding:



- Income reporting requirements for public benefit programs, including the Social Security Administration;
- Formalized development of Plans for Achieving Self Sufficiency (PASS), Property Essential to Self-Support (PESS);
- Assistance with utilization of social security work incentives;
- Coordination of Social Security and Medicaid work incentives and benefits support and
- Individual benefit verification, consultation, education and ongoing analysis/planning.

BP can be provided to individuals considering or seeking competitive integrated employment, career advancement or to individuals who need financial problem solving assistance to maintain competitive integrated employment.

This service may include activity on behalf of the individual to assist in provision of the BP service. This service may be provided in person or virtually based on the individual’s informed choice.

BP may only be provided if a Certified Work Incentives Counselor through a Missouri-based Social Security Supported Work Incentives Planning and Assistance (WIPA) program were sought and it is documented by the Support Coordinator that such services were not available, accessible or applicable due to either ineligibility or because of wait lists that would result in services not being available within 30 calendar days (this is only required once per year; i.e., it must be repeated if BP is needed in a subsequent year).

The outcome of this service is a completed Benefits Summary & Analysis and a Work Incentive Plan to support the individual with making an informed choice on employment and earned income.

Service Limitations

BP services are limited to a maximum of 60 units per annual support plan for any combination of initial BP, supplementary BP when an individual is evaluating a job offer/promotion or a self-employment opportunity, or problem-solving assistance to maintain competitive integrated employment.

Additional units may be approved by the Division’s Regional Director or designee in exceptional circumstances.

Provider Requirements

This service can be provided by an Agency Employment Service Provider, ISL, DH, or Group Home Provider or by an Individual Certified Community Work Incentive Counselor, Community Partner Work Incentives Counselor or a Credentialed Work Incentive Practitioner. An individual or agency must have a DMH contract and staff (direct or contracted) who will work directly with the participant to provide BP services shall maintain current national certification as a Certified Community Work Incentive Counselor; Community Partner Work Incentives Counselor or a credentialed Work Incentive Practitioner.

Billing Information: Benefits Planning

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
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Benefits Planning	H0038 SE	15 minutes	60 units per annual support plan year
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Benefits Planning Service Documentation

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.

Career Planning

Available in Comprehensive, Community Support, and PfH Waivers only

Service Description

Career planning is a comprehensive individualized service which supports a participant with vocational discovery, identification of career themes (pathways) and development of a plan to achieve competitive integrated or self-employment goals. The outcome of this service is documentation of the participant's stated career objective and a completed career plan/discovery profile used to guide ongoing individual employment support needs.

Career planning activities may include but are not limited to the coordination and delivery of:

- Home and neighborhood observations
- Job exploration
- Job shadowing
- Informational interviewing
- Work specific review of assistive technology
- Assessment interests and skills
- Labor market research
- Vocational and job related discovery on asset development

Providers of this service may coordinate, evaluate and communicate not only with the individual, but also with their caregivers, support team, employers, teachers and others who can assist with discovering an individual's skills, abilities, interests, preferences, conditions and needs. This support and evaluation should be provided to the maximum extent possible in the presence of the individual and should be conducted in the community, but completion of activities in the home or without the presence of the individual is not precluded.

Additional information about career planning services:

- If an individual is employed, career planning may be used to explore other ongoing competitive employment career objectives which are consistent with the person's skills and interests or explore advancement opportunities in his or her chosen career.
- Career planning should be reviewed and considered as a component of an individual's person-centered services and supports plan, no less than annually, more frequently as necessary, or as requested by the individual.
- These services should be designed to support successful employment outcomes consistent with the individual's goals.
- Transportation costs for the implementation of Career Planning services are included in the unit rate.



PCA may be provided to support an individual while receiving this service, but may not comprise the entirety of the service.

Outcomes expected for this service are as follows:

1. An identified career path and the supports needed for pursuing that career path in ways that can be identified and measured.
2. A career plan which specifies the individual's needs, interests, strengths, natural supports and characteristics of potential work environments. The plan must also specify training or skills development necessary to achieve the individual's career goals.

Career Planning furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 and its amendments or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Therefore, the case record for any individual receiving this service must document the individual is not eligible for, unable to access, exhausted services or otherwise inapplicable for the aforementioned programs as outlined in an interagency memorandum of understanding between VR and the Division of DD. Career Planning can be authorized, without a referral to VR, in those instances when:

- It is currently unknown if an individual is able to prepare, secure, retain or regain competitive employment and the individual is still exploring if competitive integrated employment is aligned with their abilities and capabilities.
- An individual has previously been determined ineligible for VR services or closed unsuccessfully from VR as "disability too severe".
- An individual has previously accessed VR and their services were discontinued as VR established thresholds of support and/or outcomes were accomplished.

Service Limitations

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

Provider Requirements

This service can be provided by an employment services provider agency. The agency must be certified by DMH or accredited by Commission on Accreditation of Rehabilitation Facilities (CARF), The Council on Quality and Leadership (CQL) or Joint Commission, to provide career planning services. The agency must have a DMH contract and comply with training requirements outlined within the contract.

Staff Requirements

All direct-care staff must be 18 years of age and have a HS 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 (1) 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 (5) 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 (5) 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 (1) month of the implementation date of the current plan, or within one (1) 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 Cardiopulmonary Resuscitation (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 (3) months of employment).
- Fourteen (14) hours of Division of DD approved training, as outlined in contract, plus an additional six (6) hours of supervised practical mentoring/job coaching related to Association of People Supporting Employment First (APSE) Supported Employment Service competencies within the first twelve (12) months of hire. Annually thereafter, employees must complete four (4) additional hours of Division of DD approved training as outlined in the contract. Any staff member who has the following credentials are deemed as meeting all training requirements:
 - Certified Employment Support Professional (CESP) by passing the national CESP examination from the Employment Support Professional Certification Council (ESPCC) or,
 - National Certificate of Achievement in Employment Services from the Association of Community Rehabilitation Educators (ACRE).
 - Direct Support Professional-Specialist-Employment Support credentialing issued by the National Alliance for Direct Support Professionals (NADSP).

Billing Information: Career Planning

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Career Planning, Individual	T2019	15 minutes	240 units per annual support plan

Career Planning Service Documentation

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.

Career Planning has implementation elements which do not require an individual be present. Duplicative billing applies only to those services where an individual is concurrently receiving “in-person” services during the same unit of time. As such, billing could occur during shared units of time with appropriate documentation.

Providers of all these services must maintain an individualized plan and detailed record of activities by unit of service. The provider is required to follow procedures set forth under The Code of State Regulations 13 CSR 70-3.030, which defines adequate documentation. ISP’s will include outcomes/goals, with criteria, and will be supported by data to demonstrate progress and implementation strategies that optimize autonomy and independence. Providers must maintain service documentation described in Section C of the DD Waiver Manual, including detailed progress notes per date of service and monthly progress notes associated with objectives.

Community Networking **Available in all Waivers**

Service Description

Community Networking (CN), formerly known as Community Integration coordinates and provides support for valued and active participation in integrated activities that build on the individual’s interests, preferences, gifts, and strengths while reflecting the person’s goals with regard to community involvement and membership.

CN services are designed to increase an individual’s connection to and engagement in formal and informal community supports. Services are designed to develop flexible, sustainable, and supportive community resources and relationships. Individuals are introduced to community resources and supports that are available in their area and supported to develop skills that will facilitate integration into their community. Outcomes for this service include positive relationships, valued community roles, and involvement in preferred community activities/organizations/groups/projects/other resources. CN outcomes are developed through a person centered planning process and provided in accordance with the ISP.

Expectations are for paid supports to be decreased and transitioned to natural supports over time when possible.

CN is not intended or designed to be used in employment settings.

PA services may be a component of CN as necessary for the individual to participate in the service but may not comprise the entirety of the service.

Transportation costs related to the provision of this service in the community are included in the service rate.

Service Limitations



This service is limited to 432 units (108 hours per month).

Individuals who receive Group Home, ISL, or Shared Living may not receive CN as it is already a component of the Group Home, ISL and Shared Living service.

Group CN may not exceed four (4) individuals per staff person.

Provider Requirements

This service can be provided by a CN agency. A CN agency is certified according to 9 CSR 45-5.010, or CARF, CQL or Joint Commission accredited to provide CN services and must have a DMH contract.

Direct contact staff must have a HS diploma or its equivalent; training in CPR and First Aid; 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 (2) years with successful completion.

Billing Information: Community Networking

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Community Networking , Individual	T2021 SE	15 minutes	432 units (108 hours per month)
Community Networking , Group	T2021 HQ SE	15 minutes	432 units (108 hours per month)

Community Networking Service Documentation

The provider must maintain all documentation as per the requirements set forth in Section C of the DD Waivers 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.

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.

Community Specialist

Available in all Waivers

Service Description

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

CS 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 DR, include advocating for the individual, and assisting the individual in locating and



accessing services and supports within their field of expertise. CS is a direct service which may require higher level of skillset and training that assist the individual in achieving their outcomes. The CS performs the implementation strategies of the outcome through direct instruction. CS staff may be part of the Person-Centered Planning process that identifies the individual's needs and desires; however, does not authorize the service nor monitors the progress of the CS service.

The services of the CS 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: ABA or PA services.

Service Limitations

CS, a direct waiver service, differs in service definition and in limitations of amount and scope from state plan TCM for person with DD. In the latter, there are waiver administrative functions performed by a support coordinator through state plan TCM that fall outside the scope of CS, such as LOC determination, free choice of waiver and provider, due process and right to appeal. Additionally, the Division of DD support coordinators facilitate services and supports, authorized in the support plan, through the regional office UR and authorization process.

A CS shall *not* be a parent, step-parent, guardian or other family member.

Provider Requirements

Providers of CS services must have a Bachelor's degree from an accredited university or college plus one year experience; be a Registered Nurse (RN) (with an active license in good standing, issued by the MO 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.

Billing Information: Community Specialist

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Community Specialist	T1016	15 minutes	96 units per day
Community Specialist, Self-Directed	T1016 U2	15 minutes	96 units per day

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 CSs 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, Community Support, and PfH Waivers**

Service Description

Community Transition services are non-recurring, set-up expenses for individuals who are transitioning from an institutional or another provider operated living arrangement to a living arrangement in a private residence.

Provider Operated living arrangements shall include any provider-owned residential setting where MO HealthNet reimbursement is available, including the following:

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

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- Essential household furnishings and moving 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, internet service set-up, water, electricity, heating, trash removal);
- Health and safety assurances, such as pest eradication, allergen control (only be rendered when the allergen control addresses the individual's disability who demonstrates a need for 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, television service or media 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.

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 60 days after the move. If additional needs for household goods or furniture are identified more than 60 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.

Service Limitations

This service is limited to persons who transition from a congregate living setting to a living arrangement in a private residence. The services must be necessary for the person to move from an institution and the need must be identified in the person's plan. Total transition services are limited to \$3,000 per individual over their lifetime in the process of moving from a congregate living setting to the community. A unit of service is one item or expense. Community Transition services may not be used to pay for furnishing living arrangements that are provider operated living arrangements where the provision of these items and services are inherent to the service they are already providing.

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

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Community Transition	T2038	1 Job	1 per month/\$3,000 Lifetime Max

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.



Counseling

Counseling was removed from the Comprehensive and Community Support waivers with dates of service on or after March 1, 2021.

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.

When providing Counseling services via telehealth, please refer to Section G: Telehealth Services in this manual for additional requirements.

Service Limitations

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

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Counseling	H0004 TG	15 minutes	32 units per day

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, Community Support and MOCDD Waivers only

Service Description

Crisis intervention provides immediate therapeutic intervention 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. This service must be available to the individual at any time of day during the approved dates of service.

Crisis intervention may be provided at home, in conjunction with Group Home, ISL or Shared Living services elsewhere in the community.

Specific crisis intervention service components 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 a formal intervention plan;
- Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions;
- Monitoring of progress and fidelity to ensure positive outcomes from interventions or to make adjustments to interventions;
- Providing intensive direct supervision when an individual is physically aggressive or when there is concern that the individual may take actions that threaten the health and safety of self or 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.
- As needed, temporary (up to 2,920 units per participant per annual support plan year) services similar to that of a DH service as in a crisis drop-in center.
- As needed, temporary (up to 2,920 units per participant per annual support plan year) 24 hour care in a crisis bed of a residence.

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. The service is to be provided by a team consisting of Crisis Technician(s) and Crisis Professional(s). Crisis teams may be agency based (certified or accredited ISL lead agencies, DH providers, and group homes), or they may be contracted to provide only this service. Crisis intervention services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from clinic services in the state plan.



Service Limitations

Crisis Intervention is intended to be time-limited. Services should be authorized through person centered planning based upon individualized assessed need not to exceed 2,920 units per individual per annual support plan year. Exceptions for services past this time limit require an amended or new ISP and approval by the relevant Regional Director. Crisis intervention needs for the eligible person that can be met through state plan, including EPSDT crisis services “for eligible persons under age 21”, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be utilized before waiver services can be provided. Crisis intervention services are limited to additional services not otherwise covered under the state plan, including EPSDT but consistent with waiver objectives of avoiding institutionalization. Children have access to any medically necessary preventive, diagnostic, and treatment services under EPSDT services to help meet children’s health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service are to improve and maintain the ability of the child to remain in and engage in community activities.

Provider Requirements

An agency must have a DMH contract.

A crisis agency; ISL lead agency; DH 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 MO (RSMo. 1994, Chapter 337). Alternately, the supervisor may be employed by the State of MO as a psychologist, clinical social worker, behavior analyst or in an equivalent position. All team members shall have at least one (1) year of work experience in serving persons with DD, 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

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Crisis Intervention, Professional	S9484	Hour	2,920 units per individual per annual support plan year
Crisis Intervention, Technician	S9484 HM	Hour	2,920 units per individual per annual support plan year



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.

Day Habilitation

Available in all Waivers

Service Description

DH services are designed to assist the individual to acquire, improve and retain the self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living (ADL) and community living. DH services may also be used to provide supported retirement activities. As people get older they may no longer desire to work and may need support to assist them in meaningful retirement activities. This might involve altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs, and/or other senior related activities in their communities. DH services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered service plan, such as physical, occupational, or speech therapy. DH may not provide services that are vocational in nature. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Activities should be appropriate to the setting and occur in the most natural setting possible to maximize transference of skill acquisition. This should *not* only occur in the facility, but on a regular basis in the community to use in a real life situations. DH services differ from the PA services in that a PA may directly perform activities or may support the individual to learn how to perform ADL's and Instrumental Activities of Daily Living (IADL's) as part of the service. DH services include all personal assistance needed by the individual. Individuals who receive Group Home or ISL, or Shared Living may receive this service; their group home or ISL budget will clearly document no duplication in service.

DH services do 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. ISPs must include outcomes and action steps individualized to what the participant wishes to accomplish, learn and/or change. The UR 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 DH Services are not utilized in lieu of basic child care that would be provided to children without disabilities. DH programs serving children should *not* co-mingle with programs serving adults at the same time in the same space. If an individual has a child of their own, supporting them to learn parenting skills may be appropriate but not as a DH service. These skills should be provided in the natural environment under a stand-alone service such as ISD or as a part of a residential service.



DH services provide regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement. DH services are provided in part with a stand-alone certified DH facility, but should be provided in any of a variety of settings in the community and not limited to fixed site facilities. Costs for transportation of individuals from their place of residence to the place where DH services are provided is not included in the DH rate, and waiver transportation may be provided and separately billed. Transportation costs related to the provision of DH services in the community are included in the service rate and may not be billed separately.

Meals provided as part of these services do not constitute a full nutritional regiment.

Group size (staffing ratio) can be no larger than six (6) and applies to activities at a facility or in the community. The group size should be appropriate for the individual and activity. [Example: Based on the activity, an individual may do well in a group of six (6), but for another activity where a higher level of support or supervision is required or when going out in the community, a smaller group size may be more appropriate.] Individualized support must be provided within a group setting. [Example: A group of people could be participating in an activity and a staff person may go from person to person in the group and provide personal support while maintaining supervision, guidance, and reinforcement to the entire group.]

Medical Exception

Individuals with exceptional medical supports needs may be granted a medical exception. Exceptional medical supports require services from the following: a certified nursing assistance (CNA), a licensed practical nurse (LPN) within their scope of practice as prescribed by the state law, a RN, or for mobility, by appropriately trained staff. The process must include the identification and rationale for staffing ratios and the level of direct care provided to meet the identified needs and be clearly documented in their support plan. The process shall include a component of professional assessment by licensed interdisciplinary team member (RN, primary care physician, OT, PT, SLP, etc.).

The intent of the Medical Exception Day Service is to provide an enhanced level of services and supports to individuals requiring the following:

- Direct care, assessment, care coordination and/or planning by a RN or an LPN (under the direct supervision and oversight of an RN) within their scope of practice and/or
- Nursing tasks that are delegated by a RN and performed by a Unlicensed Health Care Personnel under the direct supervision and oversight of a RN

Unlicensed Health Care Personnel shall be defined as the following:

- a Department of Health and Senior Services (DHSS) Certified Restorative Aide
- a DHSS Certified Medication Technician
- a DHSS CNA
- a DHSS Certified Level I Medication Aide
- a DMH DD Certified Medication Aide or
- a DMH DD Direct Support Professional



This is to promote individuals' ability to access community based services and integration to the fullest extent of their capabilities. A separate rate and code modifier is available for this service.

Support may need to be provided individually for the designated task and may be provided in a group during the remaining service time. [Example: Performing a medical task (see criteria for medical exceptions for more information)]. The size of the group may not exceed six (6), must be identified and documented in their ISP. The medical exception covers two distinct areas of need: 1) prescribed medical services; and, 2) mobility support as specifically stated in the ISP. The inherent need for increased support for people in this service to access the community, to shelter in place, or for evacuation, requires the level of support be carefully considered when determining group size to ensure the health and safety of the individual. This service may not be provided until qualified staff is in place. Requests for Exceptional medical supports must be reviewed and approved by the UR Committee and include the following documentation:

- Written documentation noting the individual's assessed need for medical services or mobility services supports by the individual's medical practitioner. When the need for this service is related to an acute condition, the written documentation from the individual's medical practitioner must be renewed annually. Written documentation from the individual's medical practitioner for chronic conditions is acceptable for the duration of the service and does not need to be renewed annually, unless changes necessitate updated information. Any request for an increase in services also requires written documentation from the individual's medical practitioner justifying this need.

When individual service is provided, the staff cannot be counted in ratio for any other group.

Mobility Support

Mobility support is defined as support needed for people who cannot propel their own wheelchair, require standby or hands-on assistance for ambulation, or require assistance to transfer to and from their wheelchair. Requests for medical exceptions due to mobility support needs must be submitted to UR Committee with written documentation noting the individual's assessed need for medical services or mobility services by the individual's medical practitioner. The staff must be trained and demonstrate competency on proper use of gait belt, lifting, transfer techniques and the specific support needs of the individual as outlined in the ISP before providing this service.

Behavioral Exception

Individuals with exceptional behavioral support needs may be granted a behavior exception when staffing is required to keep them and/or others safe. Requests for a Behavioral Exception shall be submitted to the UR committee and include one of the following types of documentation:

- An ISP inclusive of a BSP including supports to be implemented through the DH service and confirmation of ongoing ABA services. If this is not an initial request, documentation must also include a review of the progress made under the plan in the current setting. or
- An approved ISP documenting behavior supports have been recommended and are being pursued and an interim plan is in place. Providers will work with the team to develop an interim plan and train staff on its implementation while a support plan is being developed. With the Regional Office Director's approval, this service may be billed for a period not to exceed three (3) months while the development and approval of the BSP is in process. If a BSP is not in place at the end of three (3) months, a status update and request for extension



may be made to the Assistant Division Director for the region. Extensions will only be approved for one (1) month at a time. When individual service is provided, the staff cannot be counted in ratio for any other group.

PA services may be a component of DH as necessary for the individual to participate in the service but may not comprise the entirety of the service.

Service Limitations

Individuals who receive Group Home, ISL, or Shared Living services may receive this service; the contract/budget will clearly document no duplication in services. CI and ISD may be used in the community and in conjunction with (but not duplicative of) DH services if the need meets the service definition.

Provider Requirements

A DH agency is licensed according to 9 CSR 40-1,2,9, certified according to 9 CSR 45-5.010, or CARF, The CQL or Joint Commission accredited to provide DH service and must have a DMH contract.

Staff Requirements

All direct-care staff must be 18 years of age and have a HS 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 (1) 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 (5) 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 (5) 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 (1) month of the implementation date of the current plan, or within one (1) 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 to administer medications. Medication administration training *must* be updated every two (2) years with successful completion.
- Training in positive behavior support curriculum approved by the Division of DD (within three (3) months of employment).



- Staff providing medical exception supports for physician ordered medical tasks *must* be an RN, LPN under RN supervision, or an Unlicensed Health Care Personnel under the direct supervision and oversight of a RN.
- Staff providing medical exception supports for ambulation or transfer support needs *must* demonstrate competency on proper technique.
- Staff providing behavioral exception supports *must* demonstrate competency on the implementation of the BSP.

Billing Information: Day Habilitation

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Day Habilitation	T2021 HQ	15 minutes	32 units per day (8 hours)
Day Habilitation: Medical Exception	T2021 SC	15 minutes	32 units per day (8 hours)
Day Habilitation: Behavioral Exception	T2021 TG	15 minutes	32 units per day (8 hours)

Day Habilitation Service Documentation

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. ISP's will include outcomes/goals, with criteria, and supported by data to demonstrate progress and on which to base changes in strategy.

DH providers must maintain service documentation described in Section C of the DD Waivers Manual, including detailed progress notes per date of service and monthly progress notes associated with objectives.

Documentation specific to medical exceptions includes:

- Written support plan which includes clinical outcome data with criteria for reduction of supports, as relevant for the identified medical condition. Examples: a blood sugar chart, time and results of suctioning, and log notes.
- Written documentation noting the individual's assessed need for medical services or mobility services by the individual's medical practitioner.

Documentation specific to the behavioral exception service includes:

- Documentation that behavioral services have been authorized and secured or that services are in process in the DH setting.
- Documentation noting the individual's assessed need for behavioral services by the individual's Board Certified Behavior Analyst (BCBA) and/or QHCP. If this is *not* an initial request, documentation *must* also include a review of the progress made under the plan in the current setting.
- Written support plan including clinical outcome data with criteria for reduction of supports as relevant to the identified target behavior(s).

Dental

Available in PfH Waiver only



Service Description

Dental services covered in this waiver include -topical fluoride applications and therapeutic dental treatment such as pulp therapy for permanent teeth; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable.

Service Limitations

Waiver dental services are only covered for individuals age 21 and over. Dental services for individuals under the age of 21 may be accessed under the State plan as a Healthy Children and Youth (HCY/EPSDT) benefit. All medically necessary “Dental” services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. The dental services are limited to additional services not otherwise covered under the state plan.

Dental services for adults exclude the following:

Any service that may be covered under the State plan Medicaid program. The following dental services may require prior authorization: treatment for trauma of the mouth, jaw, teeth, or other contiguous sites as a result of an injury; and treatment of a disease/medical condition without which the health of the individual would be adversely affected and would result in a higher LOC. It also includes preventive services, restorative services, periodontal treatment, oral surgery, extractions, radiographs, pain evaluation and management, infection control, and general anesthesia. Service unit is one (1) visit, with a maximum of one (1) unit per day. The combined cost of all PfH Waiver services authorized for an individual, including dental services, is limited to \$12,362 per year per individual.

Dental Provider Requirements

Individual Dentist

- Current licensure as a Dentist in the State of MO 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 MO or bordering State;
- Licensed Dental Hygienists or Dental Assistants services may be included.
- A dentist is not required to enroll with the DSS 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

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Dental	T2025	1 Visit	1 visit per day, \$12,000 per year

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 – 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.

Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

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. However, the service can be used toward the purchase of the existing adaptations in a pre-owned vehicle. In these instances, dealership/vendor must be paid directly by the state. The individual will not receive any Medicaid funding to make the purchase. The dealership/vendor must provide an invoice/purchase order that only includes the vehicle adaptations and not the vehicle. The price of the adaptation is comparable to market value and shall *not* include any labor cost.

All adaptations must be recommended by an occupational or physical therapist (PT). 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 MO license number. All services shall be provided in accordance with applicable state or local building codes.

Occupational therapists (OTs) and PTs can conduct evaluations for home modifications via telehealth. The EAA procedure code S5165 with "TC" modifier (CIMOR use only) is used for these evaluations only. When providing OT or Physical Therapy (PT) services via telehealth, please refer to Section G: Telehealth Services in this manual for additional requirements.

For EAA and specialized medical equipment and supplies (SME) 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.

Service Limitations

Costs are limited to \$7,500 per annual support plan year, per individual for all Waivers. An exception may be approved by the Regional Director and DD Deputy Assistant Director with a maximum limit of \$10,000 per annual support plan year, per individual.

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.

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

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Env. Accessibility Adaptations	S5165	1 Job	1 per month \$7,500 per annual support plan year

Environmental Accessibility Adaptations-Home/Vehicle Modification Service Documentation

OT and PT providers conducting assessments/recommendations, as required for the EAA, 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. EAA 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 adaptation/modification should have properly met the individual's needs.

Family Peer Support Service Available in PfH Waiver only

Service Description



The Family Peer Support service is an array of formal and informal services and supports provided by a Family Support Partner (FSP) to families who have a family member with an intellectual/developmental disability (I/DD).

Family is defined as the primary care giving unit and is inclusive of the wide diversity of caregivers in our culture. For the purpose of the Family Peer Support service, family is further defined as the persons who live with or provide care to a person with I/DD receiving services through a waiver and may include a parent, spouse, sibling, children, relatives, grandparents, foster parents, or others with significant attachment to the individual.

A FSP provides nonclinical family peer support by sharing valuable personal knowledge based experience in supporting and providing care to a family member with an I/DD. This service may also include identifying and developing formal and informal supports, instilling confidence, assisting in the development of individual and family goals, serving as an advocate, mentor, or facilitator for resolution of issues and skills necessary to enhance and improve the health and well-being of the individual and their family unit and to help reduce caregiver stress and isolation. The Family Peer Support service builds on a family's strengths, buffers risk while building protective factors, and promotes optimal outcomes. The Family Peer Support service supports the parent/family and enhances their skills so they can effectively understand and contribute to planning processes and access services that will better promote positive functioning, which results in their family member's ability to live successfully in their home and community. The FSP assists families by providing information and training as needed to support the family to increase their ability to provide a safe and supportive environment in the home and community for their family member.

Developing positive family rapport is critical to the effectiveness of this service and, therefore, personal face-to-face visits in a variety of settings may be necessary. Face-to-face support may be supplemented by phone or electronic correspondence.

Family Peer Support services may be provided individually or in a group setting.

Family Peer Support services provided must include communication and coordination with the family and/or legal guardian and may be provided concurrent with the development of the family member's ISP. Coordination with other systems should occur as needed to achieve the family's goals.

Family Peer Support may not have more than 4 individuals in a group.

Service Limitations

Services are episodic, conditional on life events and existing circumstances of the family and not intended to be long-term and ongoing. As families develop resiliency skills, services should be faded. A FSP shall *not* deliver this service within their immediate or extended family.

Units of service are 15 minute increments. A maximum of 640 units per family can be authorized on an annual basis. Additional units must be pre-authorized by the Division's Regional Director or designee.



This service shall *not* duplicate other waiver or state plan services including, but not limited to: TCM, CS, Support Broker, or Respite Care.

Provider Requirements

A Family Support Organization has a DMH Contract; agency employs an individual with the following qualifications:

- Be a parent or family member.
- Have at least five years of lived experience supporting a family member with I/DD. Lived experience must be relevant to the purpose of this service and will include a personal history of being actively involved in providing care and support for the individual and their family members.
- Be at least 18 years of age and have a HS diploma or its equivalent.
- FSPs without diplomas or GEDs may be employed for up to one year while they work to attain the requirement. The provider must document the staff's enrollment in school or GED courses within 60 days from the date of employment.
- Pass all required criminal and background checks.
- Successfully attend and complete orientation, DMH approved curriculum/training(s), and certification exam related to position.
- Have access to transportation in order to meet the requirements of the position.

Billing Information: Family Peer Support Service

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Family Peer Support	-S5110 Individual -S5110 HQ Group	15 minutes	640 units per year per family

Family Peer Support Service Documentation

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.

Group Home

Available in Comprehensive Waiver only

Service Description

Group home services provide care, supervision, and skills training in ADL's, home management and community integration. This includes assistance and support in the areas of self-care, sensory/motor development, interpersonal skills, communication, community living skills, mobility, health care, socialization, money management and household responsibilities. The services are provided to individuals who live in group homes, residential care centers, and semi-independent living (SIL) situations (clustered apartment programs) certified by DMH 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 home service settings are provider-owned or controlled, and therefore must also ensure compliance with 42 CFR 441.301(c)(4)(vi).

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

Group home services include non-medical transportation for individuals to access the community. While transportation is a component of the group home rate, additional transportation may be authorized when an individual accesses work or DH through the transportation waiver service. Staff are responsible to ensure transportation to medical appointments and for health care needs but provider costs for those services must be billed to the State Plan.

The DMH regional offices assure no duplication in payment for this service.

For individuals hospitalized, staffing supports normally provided through group home services may assist with supports, supervision, communication, and any other supports that the hospital is unable to provide. The service will: be identified in an individual's person-centered service plan; provided to meet needs of the individual that are not met through the provision of hospital services; not substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and be designed to ensure smooth transitions between acute care settings and HCB settings, and to preserve the individual's functional abilities.

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

- Staff provided assistance and support in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, money management and household responsibilities. Also included are the salary, benefits, and training costs of direct program staff, supervisory staff, and purchased personnel who provide services in these areas;
- Habilitation supplies and equipment that are *not* specifically prescribed for one individual;
- Necessary staff supervision up to 24 hours per day; and
- Agency administration for habilitation services.
- Group home providers are required to provide up to 1.25 hours/month of Registered Nursing services as needed by the individual.

SUPPORTS AND SERVICES PROVIDED IN GROUP HOMES

Residential Monthly Registered Nurse Oversight

The 1.25 RN service requires a monthly face to face assessment, monthly review of the individuals health/medical information, oversight and supervision of nursing task delegated (in accordance with MO Nurse Practice Act 335.016(10), RSMo 2000 to Unlicensed Assistive Personnel (UAP) or LPN and their scope of practice) monthly reporting and documentation of findings and request for follow-up to the service provider agency. This would include but is not limited to reporting all changes in health status to the physician and the support team.

Individuals who have health care needs that exceed 1.25 hours/month can request additional hours through the UR process. The amount will be specified in each person's ISP and would bill under the



waiver code Residential Monthly RN Oversight. In addition to the Residential Monthly RN Oversight requirement, providers may utilize Residential LPN (with RN oversight) when the individual need is identified through the ISP. The RN or LPN service will be authorized separately and billed in 15 minute increments. Maximum Quantity 48 units per day.

Residential Monthly RN Oversight is intended to promote and support an optimal level of health and well-being for the individual. The service may include nursing assessment and care of the individuals identified condition(s) or healthcare needs and planning to include instructions and training for caregivers when indicated and coordination and communication with the individual, their caregivers and the support team.

The service may be utilized to:

- a) Evaluate care needs; an example would be a visit to determine whether the desired outcomes have been met or how well the plan of care is working and if the plan of care needs to be modified.
- b) Plan appropriate supports including instructions for caregivers; an example would be staff training related to a disease or condition such as seizure precautions or recognizing reportable signs and symptoms.
- c) Complete a physical assessment of condition; an example would be assessing a worsening of a chronic condition or an acute change in health or functional status.
- d) Assess the care environment; an example would be to assess the ability of the individual to safely access their environment and the need for minor changes and /or a referral to an OT/PT for environmental adaption or change.
- e) Administer injections; an example would be administering a monthly vitamin or hormone injection.
- f) Perform complex nursing treatments; an example would be assessing and suctioning the airway or dressing a wound that requires evaluation of healing and absence of complications.

All services must be documented and available as a component of the individual record. Documentation must include an individualized plan of treatment and detailed record of intervention activities by unit of service. The provider of service is required to follow procedures set forth under The Code of State Regulations 13 CSR 70-3.030, which defines adequate documentation.

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.

Children under the age of 21 may be eligible and qualify for private duty nursing under the Medicaid State plan. It is unlikely that Residential Monthly RN Oversight services would be utilized by this population related to the vast array of services available.

This service shall be provided by a RN with an active license to practice to the extent allowed by their respective scope of practice in the State of MO.



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.

Service Limitations

In some cases, individual transportation is included in the rate, when the facility is equipped to routinely provide rides to DH provided at a stand-alone licensed or DH 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; immediate family for purposes of group home services, includes parent, child, sibling, spouse or legal guardian.
- 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.

Individuals who receive group home services shall *not* receive waiver PA services, ISD, or CN Services because these services are already components within the service. PA, ISD and CN are already components of the group home service and funded under the group home service.

Provider Requirements

This service can be provided by a Community Residential Facility or a SIL 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 SIL arrangement shall be licensed according to 9 CSR 40-1, 2, 4, 7; 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 ISL budget. The budget shall reflect the approved staffing plan.

Staff Requirements

All direct-care staff must be 18 years of age and have a HS 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 (1) 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 (5) 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 (5) 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 (1) month of the implementation date of the current plan, or within one (1) 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

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Group Home	T2016 HQ	Day	1 per day
Group Home-Intensive	T2016 HQ	Day	1 per day
Group Home-Transition	T2016 HQ	Day	1 per day
Residential Monthly Registered Nurse Oversight	T1002 HQ	15 minutes	48 units per day (12 hours)
Residential Licensed Practical Nurse (with Registered Nurse Oversight)	T1003 HQ	15 minutes	48 units per day (12 hours)
Residential Hospital Supports	S5125	15 minutes	96 units per 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.

Health Assessment and Coordination Services

Available in all Waivers

Service Description

Health Assessment and Coordination (HAC) services are consultative telemedicine services designed for individuals with I/DD receiving HCBS Waiver services. The services are intended to coordinate care with local emergency departments, urgent cares, and primary care physicians to enable real time support, consultation, and coordination on health issues. HAC services assist individuals, families, and support providers in understanding the health symptoms with which individuals present in order to identify the most appropriate next steps. Services are available 24 hours a day, 7 days a week and include immediate evaluations, video-assisted examinations, treatment plans, and discussion and coordination with individuals and/or caregivers.

HAC services provide disability-specific advice regarding instances when it is appropriate to seek additional medical treatment. HAC services can occur while the person is in their home. The services are a conduit to, rather than a duplication of, medical services covered under the state plan. In addition to assessing the need for medical attention specific to individuals with I/DD, HAC services include support and consultation to families and direct support professionals (DSPs). This component builds the capacity of families and DSPs (who do not possess medical credentials) to



better understand the best approaches for supporting the individual depending on their symptom presentation.

HAC services provide a real time health assessment to determine the best clinical course of action, often avoiding unnecessary emergency room visits. If a hospital visit is clinically necessary, this service allows the HAC services provider to communicate with the emergency department (ED) directly, ensuring advance preparation for the ED.

HAC services include follow-up consultations with the individual or family and/or caregiver of the individual within 18 hours of the initial call.

Service Limitations

HAC services are not to duplicate any service available through the state plan nor shall they replace in-person exams when they are needed. These services do not replace the need for an individual to have a primary care physician.

The costs of HAC services shall not exceed the Medicaid maximum rate per year, per individual.

Provider Requirements

The provider must satisfy the following requirements:

- a. Be licensed in the State of Missouri, or have appropriate reciprocity;
- b. Be licensed by the American Board of Medical Specialties (ABMS);
- c. Be board certified or board eligible (MD/DO); and
- d. Have completed specialized training/curriculum to care for individuals with developmental disabilities.
- e. Have a minimum of four (4) years' experience in serving individuals with developmental disabilities in their own homes, family homes, individual residential alternatives (IRAs), Intermediate Care Facilities (ICFs), as well as other types of long-term supports and services.
- f. Have demonstrated evidence of positive outcomes for individuals served.
- g. Provide continuing education in the area of intellectual and developmental disabilities to the provider's physician network.
- h. Meet technological and privacy requirements as set forth by the state.
- i. Must submit to the Division, prior to contract and at each contract renewal, successful results from a self-assessment validating staff qualifications, required documentation, policies and procedures.
- j. Have a participant support call center that is staffed 24 hours a day, 7 days a week.
- k. The provider must have references related to the provider's business history and practices.
- l. The provider must have a comprehensive quality review program and provide a report via secure e-mail of their aggregated findings at the end of each month, as well as one time annually, to the state agency, which must include, at a minimum, the following:
 - a. Data analysis;
 - b. Service outcomes;
 - c. Individual, family and/or caregivers of individuals, and provider satisfaction; and
 - d. Complaints and resolution.

Billing Information: Health Assessment and Coordination Services



Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Health Assessment and Coordination Services	99499	per month	One (1) per month, twelve (12) per individual per annual support plan year.

Health Assessment and Coordination Services documentation

The provider shall document the provision of authorized services and consumer progress.

The provider shall document and maintain records of services provided and consumer progress. In the event the provider provides waived services, the provider shall document and maintain records of waived services in accordance with any Medicaid requirements.

Service records shall be provided to the Department, as requested, and shall include, but are not limited to the information listed below:

- Service type and number of units provided
- Activity related to the personal plan
- Date of service and the start and end times
- Name of the staff person providing the service
- Name of the consumer receiving services
- Location where services were provided
- Signature and title of the program supervisor/provider
- Other information deemed necessary by Department

Home Delivered Meals

Available in the Community Support Waiver only

Service Description

Home-Delivered Meals (HDM) means the preparation, packaging and delivery of meals to individuals who are unable to prepare or obtain nourishing meals. The intent of HDM is to allow individuals to remain in their natural home without paid staff who would not otherwise be able to without the delivery of meals. A full regimen of three meals a day shall *not* be provided under the HCBS waiver.

The provision of HDM is the most cost-effective method of ensuring a nutritiously adequate meal. The goal of the HDM service is to supplement, not replace, the local home-delivered meal services provided at no cost. HDM must be in lieu of paid staff. This service alone or in conjunction with other services benefits health, enhances independence, promotes quality of life, and prevents institutionalization of the individual.

The individual must:

- Be unable to prepare some or all of his or her own meals;
- Have no other natural support to prepare his or her own meals; and
- Have the provision of the HDM included in his or her ISP.



Providers of HDM shall:

- Initiate new orders for HDM within seventy-two (72) hours of referral if specified by the ISP;
- Have the capacity to provide two (2) meals per day, seven (7) days per week;
- Assure that HDM are delivered to each individual in accordance with the individual's ISP;
- Ensure that each meal served contains at least one-third of the current recommended dietary allowance as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council;
- Shall provide special menus to meet the particular dietary needs arising from the health requirements, religious requirements or ethnic backgrounds of service recipients, where appropriate;
- Plan, prepare and serve special meals for health requirements under the supervision/consultation of a dietitian;
- Train the person(s) responsible for the service of special diets to make appropriate substitutions based on food values.

Service Limitations

A full regimen of three meals a day shall *not* be provided under the HCBS waiver. No more than two (2) HDM will be authorized for each day. A maximum of 14 meals per week.

A unit of service is a meal.

The individual's ISP addresses how the individual's health care needs are being met. Services will be monitored by the support coordinator through the ISP to avoid duplication with other services.

The utilization of HDM may not occur if another paid or natural support is required during the meal time.

Provider Requirements

This service can be provided by an Agency Home Delivered Meal Provider. An agency must have a DMH Contract as a Home Delivered Meal Provider and enrolled through MMAC. HDM providers shall comply with the sanitation standards and processes contained in the DHSS Food Code manual, as referenced in 19 CSR 20-1.025. HDM providers shall provide an assurance in their area plans that any person who provides or applies to provide direct services in the home will be checked against the Family Care Safety Registry and Employee Disqualification List;

There shall be an administrator who shall be responsible for the operation of the service center and the service. The administrator, or a person designated by the administrator, shall be present in the service center at all times the service center is open;

There shall be an adequate number of staff (paid or volunteer) who are qualified to perform assigned functions in order to implement the activities and services of the service center.

Billing Information: Home Delivered Meals



Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Home Delivered Meals	S5170	1 meal	2 meals per day/14 meals per week

Individual Directed Goods and Services

Available in all Waivers

Service Description

IDS refers to a service, support, or good that enhances the individuals' opportunities to achieve outcomes related to full membership in the community.

Each service, support or good selected must meet each of the following eight criteria.

1. The service, support or good is designed to meet the individual's safety needs, community membership and also advances the desired outcomes in his/her ISP;
2. The service, support or good must increase independence, substitute for human assistance;
3. The service, support, or good must reduce the need for a Medicaid waiver service;
4. The service, support or good must have documented outcomes in the ISP;
5. The service, support or good is not prohibited by Federal and State statutes and regulations;
6. The service, support or good is not available through another source and the person does not have the funds to purchase it;
7. The service, support or good will be acquired based upon anticipated use and most cost-effective method (rental, lease, and/or purchase); and
8. The service, support or good *must not* be experimental or prohibited.

Service Limitations

Costs are limited to \$3,000 per annual support plan year, per individual. The annual limit corresponds to the person-centered service plan year.

Provider Requirements

This service can be provided by The Vendor Fiscal/Employer Agent Financial Management Services must comply with all requirements specified in the current contract between the Vendor Fiscal/Employer Agent and the Missouri Department of Mental Health.

Billing Information: Individual Directed Goods and Services

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Individual Directed Goods and Services	T2028	1 job	\$3,000 per annual support plan year per individual

Individualized Skill Development

Available in all Waivers

Service Description

ISD are individualized supports, delivered in a personalized manner, to support individuals who live in their own or family homes with acquiring, building, or maintaining complex skills necessary to maximize their personal independence. Teaching methods are individualized to what the participant



wants to accomplish, learn and/or change based on the identified skill as developed in the person-centered planning process and provided in accordance with the ISP to achieve identified outcomes.

Complex skills development include but is not limited to domestic and home maintenance, budgeting and money management, and using public transportation. Transportation costs related to the provision of this service in the community are included in the service rate.

This is an episodic support of a clearly identified skill as developed through a person centered planning process and provided in accordance with the ISP the provider must document monthly progress toward achieving each skill identified in the ISP which shall include an annual review of progress towards the individual's independent living goals.

PA services may be a component of ISD as necessary for the individual to participate in the service but may not comprise the entirety of the service.

The UR 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.

Service Limitations

Individuals who receive Group Home, ISL, or Shared Living may *not* receive this service because it is encapsulated within these aforementioned services and would cause duplication. A person who receives these services may receive DH, but may not receive ISD at the DH location.

This service is limited to 348 units, 87 hours a month.

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, educationally related services and support that is the responsibility of local education authorities, nor shall it supplant services through EPSDT.

This service may not be provided by a family member or guardian.

Group ISD may not have more than four (4) individuals in a group.

Additional ISD Limitations:

- This service may *not* be provided by a family member or guardian.
- Group ISD may *not* have more than four (4) individuals in a group.
- A national/state credentialed staff trained in skill development will be required.
- Payment is on a 15 minute, fee for service basis.

Provider Requirements

This service can be provided by an ISD agency or DH agency. An ISD agency is certified according to 9 CSR 45-5.010, or CARF, CQL or Joint Commission accredited to provide ISD services. The agency must have a DMH contract and staff that have successfully completed the state credential process.



A DH agency is licensed according to 9 CSR 40-1,2,9, certified according to 9 CSR 45-5.010, or CARF, CQL or Joint Commission accredited to provide ISD service and must have a DMH contract. Direct contact staff must have a HS diploma or its equivalent; training in CPR and First Aid; state credentialing in skill development. Program staff administering medication must have successfully completed a course on medication administration approved by the DD regional office. Medication administration training must be updated every two (2) years with successful completion.

Billing Information: Individualized Skill Development

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Individualized Skill Development, Individual	S5108	15 minutes	348 units per month
Individualized Skill Development, Group	S5108 HQ	15 minutes	348 units per month

Individualized Skill Development Service Documentation

The provider must maintain all documentation as per the requirements set forth in Section C of the DD Waivers 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.

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.

Individualized Supported Living

Available in Comprehensive Waiver only

Service Description

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. ISL is characterized by creativity, flexibility, responsiveness and diversity. ISL enables people with disabilities to be fully integrated in communities. 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. Services are designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in HCB settings. ISL services may also include assistance with ADL and assistance with IADL, depending upon the needs of the individual. Services may include up to 24 hours of support as specified in his/her ISP.

ISL reflects these four (4) sets of principles (further described in 9 CSR 45-5.010):

- (A) Community Membership
- (B) Self-determination
- (C) Rights



(D) Meeting Basic Needs

ISL service delivery models must include the following components:

Direct Support, which includes:

- Direct Support Staff
- Professional Management, responsible for
 - Staff training and supervision;
 - Quality enhancement monitoring;
 - Direct plan implementation for individuals as needed;
 - Monitoring implementation of outcomes;
 - Establishing information collection systems;
 - Writing monthly reviews;
 - Oversight/coordination of all the person's programs and services being received;
 - 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, day program, case manager, physicians, etc.
 - Transportation and monthly RN oversight are provided through an ISL provider, in conjunction with the ISL service, but are authorized separately and *not* included in the daily rate. ISL providers are required to bill these services with the applicable transportation or monthly RN oversight codes and modifiers.

ISL can be used in conjunction with an array of employment supports.

The home in which a person receives ISL services is a private dwelling, not a licensed facility and must be owned or leased by at least one (1) of the individuals residing in the home and/or by someone designated by one (1) of those individuals such as a family member or legal guardian.

If individuals choose to live with housemates, no more than four individuals receiving ISL services may share a residence. Each individual in the home has free choice of provider and is not required to use the same ISL provider chosen by their housemates. 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.

Reporting Under Served Provisions to MMAC

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 MMAC Unit on at least an annual basis.

Under Served Reporting Process:



- Providers evaluate service provision utilizing internal systems no less than annually as established by provider policy. Each provider shall establish a written policy which defines the year of service being utilized for service reporting. The year may or may not follow ISP timelines and may differ by service site, as prescribed by the policy. If the year differs by service site, the provider shall design a reporting system to describe the timeline for each site.
- A variance report may only be submitted when service provision has been tracked for an entire year or from the beginning of the established year through the date the service was terminated.
- Provider submits the “DD Waiver Variance Calculation Worksheet” (previously known as the “ISL Variance Calculation Worksheet”) found at the following link by clicking on DMH Providers Reporting Variance.
 - Each provider shall establish a written policy describing the uniform methodology utilized for determining the Direct Care hourly rate. For example: Direct Care hourly rate less any costs associated with other costs of doing business (administration fee, case coordination, professional manager, etc.)
- MMAC will make a recoupment (this means the provider should *not* send payment with the DD Waiver Variance Calculation Worksheet or adjust any claims as this may cause duplicate recoupments.)

Examples of Under Serviced Provisions

- Individualized hours (1:1, 2:1, etc.) budgeted per the staffing pattern are not utilized
- Shared hours (1:3, 2:3, 3:4, etc.) budgeted does not occur. Indicating staff are not required to work and under variance would be reported for each consumer.

Reporting Over Serviced Provisions to the Division

- Providers evaluate service provision utilizing internal systems no less than annually as established by provider policy or upon service termination.
- A report may only be submitted when service provision has been tracked for an entire year or from the beginning of the year through the date the service was terminated. An exception may be made on a case by case basis for reimbursement prior to the end of the year should there be extenuating circumstances.
- Provider submits a variance report to the responsible Regional Office or Satellite Office
- Variance Report Committee using the ISL and Shared Living Variance Reporting Form.
- Variance Report Committee reviews request and justification and requests any additional information needed.
- Upon receipt of all information, the committee communicates their decision in writing (email, fax or letter) to provider within ten (10) business days of the review. The Division adjusts the ISL budget one time on a future months billing.

Examples of Over Serviced Provisions Which Will Be Approved When Budget Does Not Have Time Built In That Can Be Utilized and Additional Staff Is Required:

- Individual periodically stays home sick from routine day schedule.
- Individual periodically chooses to stay home from routine day schedule.
- Individual(s) home due to known closure when budget has not yet been annualized.
- Individual(s) home due to unplanned closure of program, employment, etc.
- 1:1 provided to attend dr.’s apt.



- Staff provided for temporary (no more than 1 week) post medical care such as same day surgery.
- Temporary additional shared staffing required due to a natural or manmade emergency such as fire, flood, electrical outage, ice storm, home invasion.

Examples of Over Serviced Provisions Which Will Not Be Approved

- 1:1 for Dr.'s apt when 1:1 is built into the staffing pattern.
- 1:1 hours went over due to community integration.
- Increases due to "behaviors" without approval from the RO within 2 business days of occurrence.
- Increase was semi-permanent (no known end date) or permanent and provided without RO UR approval.

Examples of When a Budget Change Is Required and Not the Use of the Variance Reporting

- Roommate is out of the home to the extent that the redistribution of the absent days results in less than the full months payment therefore shared staffing would not be paid in full.
- Additional hours needed for a semi-permanent situations such as 6 week treatments for OT, PT, or a medical treatment.
- Individual starts or stops attending routine daily out of the home programming.
- Individual requires continuing increased hours due to health deterioration.
- Individual requires 1:1 due to medical procedure after care for more than 1 week.
- Any permanent increase or decrease to staffing pattern due to individual specific situation.

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 ADL's and assistance with IADL's, people who use ISL will not also receive state plan personal care.

Individuals who receive ISL services may also receive DH services, ABA, Supported Employment, Crisis Intervention, etc. and other waiver services that are identified as needs through the person centered planning process as long as there is no duplication with the ISL service and it is not included in the ISL budget.

If "Other" is listed on the ISL budget, it must be indicated in the ISP regarding the need for "Other" and will be required to meet the adequate documentation requirement.

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 12 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.

As a component of ISL services, providers are required to provide each individual a monthly minimum of 30 minutes of contact by a RN. The amount will be specified in the individual'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 codes ISL Monthly RN Oversight. In addition to the ISL Monthly RN Oversight requirement, providers may utilize ISL Monthly LPN (with RN oversight) when the individual need is identified through the ISP. ISL Nursing will be authorized on an annual basis; enabling a provider flexibility to provide services as needed, with the expectation that a minimum of 30 minutes be provided each month. Maximum Quantity 48 units per day.

ISL Monthly Registered Nurse Oversight Description

ISL Monthly RN Oversight is intended to promote and support an optimal level of health and well-being for the individual. The service requires a monthly face to face assessment, monthly review of the individuals health/medical information, oversight and supervision of nursing task delegated (in accordance with MO Nurse Practice Act 335.016(10), RSMo 2000 to UAP or LPN and their scope of practice) monthly reporting and documentation of findings and request for follow-up to the service provider agency. This would include but is not limited to reporting all changes in health status to the physician and the support team. The service may also include additional nursing assessment and care of the individuals identified condition(s) or healthcare needs and planning to include instructions and training for caregivers when indicated and coordination and communication with the individual, their caregivers and the support team.

The service may be utilized to:

- a) Evaluate care needs; an example would be a visit to determine whether the desired outcomes have been met or how well the plan of care is working and if the plan of care needs to be modified.
- b) Plan appropriate supports including instructions for caregivers; an example would be staff training related to a disease or condition such as seizure precautions or recognizing reportable signs and symptoms.
- c) Complete a physical assessment of condition; an example would be assessing a worsening of a chronic condition or an acute change in health or functional status.
- d) Assess the care environment; an example would be to assess the ability of the individual to safely access their environment and the need for minor changes and /or a referral to an OT / PT for environmental adaption or change.
- e) Administer injections; an example would be administering a monthly vitamin or hormone injection.
- f) Perform complex nursing treatments; an example would be assessing and suctioning the airway or dressing a wound that requires evaluation of healing and absence of complications.

All services must be documented and available as a component of the individual record. Documentation must include an individualized plan of treatment and detailed record of intervention activities by unit of service. The provider of service is required to follow procedures set forth under The Code of State Regulations 13 CSR 70-3.030, which defines adequate documentation.



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.

Children under the age of 21 may be eligible and qualify for private duty nursing under the Medicaid State plan. It is unlikely that ISL Monthly Registered Nurse Oversight services would be utilized by this population related to the vast array of services available.

This service shall be provided by a RN with an active license to practice to the extent allowed by their respective scope of practice in the State of MO.

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 individual resides in the home of a caregiver or in a home owned or leased by the lead agency.

For individuals hospitalized, staffing supports normally provided through ISL services may assist with supports, supervision, communication, and any other supports that the hospital is unable to provide. The service will: be identified in an individual's person-centered service plan; provided to meet needs of the individual that are not met through the provision of hospital services; not substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and be designed to ensure smooth transitions between acute care settings and HCB settings, and to preserve the individual's functional abilities.

Service Limitations

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.

If individuals choose to live with housemates, no more than four (4) individuals receiving ISL services may share a residence.

Because the ISL service includes assistance with ADL's and assistance with IADL's, people who use ISL also will not receive state plan personal care.

The ISL service includes components of PA, ISD and CN within the service implementation; therefore PA, ISD and CN services are cannot be authorized in addition. PA, ISD and CN are already components of ISL service and funded under the ISL service.



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 HS 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 (1) 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 (5) 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 (5) 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 (1) month of the implementation date of the current plan, or within one (1) 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

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Individualized Supported Living	T2016	Day	1 per day
Individualized Supported Living Transportation, Staff Vehicle Mileage	T2001	Mile	
Individualized Supported Living Transportation, Agency	T2001 HQ	Month	1 per month
Individual Supported Living Monthly Registered Nurse Oversight	T1002 TD	15 minutes	48 per day
Individual Supported Living LPN (with Registered Nurse Oversight)	T1003 TE	15 minutes	48 per day
Hospital Supports	S5125	15 minutes	96 units per 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.

Intensive Therapeutic Residential Habilitation

Available in Comprehensive Waiver only

Service Description

Intensive Therapeutic Residential Habilitation (ITRH) is a HCB clinical treatment model with an integrated treatment team designed to prepare the individual for full or partial reintegration into the community in the least restrictive or more natural setting. A plan for a transition, fading of supports, and referral of services must be included in the individual's treatment plan. The service is selected by the person supported, or their representative, as appropriate. It is designed to meet the specific and individualized assessed needs of each person receiving the service and supports, to the maximum extent appropriate, each individual's independence and full integration into the community. It ensures, to the maximum extent appropriate, each individual's choice and rights; and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices. The ITRH service will prepare the person for full or partial reintegration into the community in a less restrictive or more natural setting by helping the individuals and support teams to establish behavioral repertoires that facilitate developing a healthy lifestyle, and daily lives filled with engaging and productive activities. This service is designed to be flexible enough to respond to the changing levels of need of the person supported and the level of risk presented by the person's current behavior, with the goal of helping the person transition to a more integrated setting in the future. It is not an indefinite, long term, residential support service.

The problems with behavior and any related medical conditions or prescribed psychotropic medications are a central focus of ITRH. There will be quantitative evaluation of psychotropic medications relevant to the symptoms for which they were prescribed and interventions designed to lessen the need for such medications. Documentation of the quantitative evaluation and collaboration with medical professionals responsible for the medication will be included in progress reports. The medical professionals prescribing and overseeing medications are responsible for the medication regime. There should be efforts of ongoing collaboration and utilization of best practices to evaluate need and effectiveness of medications and environmental/behavioral interventions.

The individual must have a BSP with specified evidence based strategies, developed within 45 days of initiation of the service. All services will meet the standards of best practice set forth by the Division, and reviewed at least every six (6) months through the Behavior Support Review committee and at least annually by the approved Due Process Committee.



Characteristics of persons served— ITRH service is accessed by 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 severe maladaptive behaviors. Need for this service is demonstrated by individuals exhibiting high risk behavior, placing themselves and or others in danger of harm, and whose person-centered plan reflects the positive interventions and supports used prior to this service, and less intrusive methods of meeting the need that have been tried but did not work.

Behaviors meet one (1) or more of the following conditions in the six (6) months that precede the consideration of referral:

1. At least two (2) incidents of dangerous behaviors that caused injury (to self or others) the treatment of this injury required emergency room, outpatient services or inpatient care from a physician or other health care professional to self or others.
2. At least two (2) incidents of dangerous behavior that creates a life-threatening situation, and that are not accidental by products of less intensive undesirable behaviors.
3. Set a fire in or about a residence or other occupied building or other dangerous location in the past year, and demonstrates continued interest in fires or threatens to repeat the act.
4. Attempted suicide with actions beyond ideation or threats.
5. A repeated pattern of incidents that caused damage to property in excess of \$2,000 in value for one (1) episode.
6. Engaged in at least one (1) episode of behavior that resulted in arrest and forensic confinement or in behaviors that could have resulted in arrest or confinement if charges were filed
7. Engaged in non-consensual sexual behavior or sexual behavior with a person who is unable to consent, or engaged in public displays of sexual behavior.
8. If the supervision or environment of the person has been such that the person lacks opportunity for engaging in the serious behaviors, a LBA must determine that the behavior would be likely to occur. Documentation of evidence of such must be provided through rates of related behaviors or simulation situations that probe likelihood of challenging behaviors.
9. *Engaged in behavior not controlled with less restrictive means and necessitated the use of physical restraints five (5) more times in one (1) month.
10. *Requires visual supervision during all waking hours and intervention to prevent imminently likely significant behaviors as described above.
11. *Has a recurrent pattern of psychiatric hospitalization for out of control behavior, danger to self or others, with at least three (3) hospitalizations of 96 hours or more in the past six (6) months.
- 12.*Has had two (2) or more of disruptions in living situation or service provider attribute to behavioral issues in the past year.
- 13.*In the past six (6) months behavioral interventions implemented correctly and consistently were ineffective in less restrictive settings and the behaviors have continued to escalate.

*Items indicate need for corroboration regarding severity of episode and that the result was not due to unskilled supports or failure of implementation of strategies.



If the supervision and environment is such that the person lacks opportunity for engaging in the serious behaviors, the behavior analyst providing oversight or services in the situation must determine that the behavior would be likely to occur at least every six (6) months if the person is without the supervision or environment provided and document evidence of such in the recipient's records. Evidence of such likelihood must be provided via rates of related behaviors, simulation situations which probe likelihood of challenging behaviors and allow opportunity for demonstration of functional alternative behaviors, or other empirical support.

If behavioral issues such as the above have occurred outside of the time frame indicated or at a lesser severity than indicated but professional judgment of a Division of DD professional designated by the Regional Director recommends upon review of documentation and consultation with family and supports that intensive behavioral services are warranted this can be sufficient indication of need.

An individual will be determined to be appropriate for this service following a review completed by the Chief Behavior Analyst or designee of the Chief Behavior Analyst or Director of the Division of DD. The review will include documentation including graphic displays of effects of services and strategies and may include observation of the individual and may include observation and interview with the individual and their current support team.

Subsequent evaluation of continued need for ITRH services will be completed at least annually, by the Chief Behavior Analyst or designee and will include a review of documentation including graphic displays of effects of services and strategies and may include observation of the individual.

Supports and Services Provided in ITRH:

In some cases, individual transportation is included in the rate, when the facility is equipped to routinely provide rides to DH provider at a stand-alone licensed or DH 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.

1) Professional assistance to participants to develop and implement:

- (a) Strategies for effectively relating to caregivers and other people in the waiver participant's life; and
- (b) Direct interventions to decrease aggressive, destructive, and sexually inappropriate or other behaviors that compromise his or her ability to remain in the family home and community (e.g. skill training, specialized cognitive counseling, development and implementation of a positive BSP).
- (c) A person with high risk behavior receiving services will have opportunities to develop a lifestyle which includes developing healthy and meaningful relationships with others.
- (d) Intervention and supports must also include the arrangement of contingencies designed to improve or maintain performance of ADL. This would occur when a recipient, for example, does not bathe regularly and this is resulting in the person being socially isolated. The objective in this case would typically be to establish acceptable bathing routines in the absence of highly engineered contingencies. In these cases, incidental teaching is provided. For example, a person is provided instruction while getting dressed in order to assist the person in learning to select appropriate clothing for a specific job site, or compliance with medical regime. An individual with diabetes may be assisted to learn to manage his/her



illness as much as possible, taking blood glucose levels, determining daily diet and medications. In this way, teaching on basic skills is provided as one component of active treatment

2) Behavioral Support Plan:

- (a) Functional Assessment of behavior, which takes into account the overall quality of a participant's life; factors that increase the likelihood of both challenging and positive behavior; underlying physical and/or mental health conditions; and the function or purpose of the challenging behavior; and
 - (b) Development of an Intervention Plan, based on the Functional Assessment, which includes strategies for improving the participant's overall quality of life; to include:
 1. therapeutically appropriate activities in the participant's day;
 2. teaching methods and environmental changes designed to decrease the effectiveness of the challenging behavior and
 3. increase the effectiveness of positive behavior in achieving desired outcomes, enhanced reinforcement for engaging in desirable behaviors, therapeutic teaching sessions and practice of skills
- 3) Treatment goals that are objective and measurable. The goals must relate to a decrease in challenging behaviors that impede quality of life for the participant and family as well as an increase in skill development as it relates to the challenging behavior. All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include, to the maximum extent appropriate and preferred by the individual, opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources.
- 4) Positive support strategies that are individualized and coordinated across all environments, such as home, school, and community, in order to ensure a consistent approach among all involved persons.
- 5) Fading of supports shall be a planned part of the course of services. Although, recipients of intensive behavioral residential habilitation programs are not able to function independently without continuous teaching, supervision, and support by others, near the end of treatment a significant reduction in intensity of service needs and rates of problem behavior may occur, even so services will remain comprehensive and continuous. At this stage, because the goal is to ensure that gains made are maintained in settings other than the treatment setting, the focus and design of services may be to prompt and practice in less structured settings and design fading of obvious supervision. The service team will plan for the eventual transitioning of behavioral improvement of the recipient to a less intense service alternative and implement strategies with the guardian, service coordinator, and regional office. The fading of supports will include planned trials with more typical supervision and activities that include back up contingencies to maintain safety of the individual and others if the need arises.
- 6) There will be a carefully monitored transition process and preparation of the selected community supports following the achievement of goals and determination that less intensive supports may be appropriate. The individual's hopes and desires as well as any family or guardian input will guide the selection and preparation of the future supports. These supports will be performance trained in the use of the successful strategies. Regular meetings with the individual and supports will occur for at least one year following the transition. The Chief Behavior Analyst or designee and the regions provider relations staff, quality assurance staff, and community living



coordinator of the region selected by the individual will participate in the transition planning and ongoing monitoring.

Service Limitations

Individuals will access this service when confirmed by the Chief Behavior Analyst or designee as meeting the highest level of need criteria. Referrals will be generated from persons supported who have been served at the highest levels of need in terms of intensity, supports, and services, yet have received minimal benefit from services at said level, and for whom ITRH services offer a more appropriate and cost-effective service delivery model. Referrals may also be generated for persons entering the system who have issues identified that are consistent with those noted for the target population and for whom ITRH services offer a more appropriate and cost-effective service delivery model than services the person would otherwise require. The Chief Behavior Analyst or designee will review referrals from state service coordinators, independent service coordinators, and DD providers. For each person referred for this service, the review will include the following information: ISP, risk assessment, clinical assessments, and health evaluations. ITRH may be selected by the individual and offered only after alternative approaches have been tried and documented to be unsuccessful. At the onset of services and throughout the service the service provider and ISP team must engage in planning and actions towards transitioning to less restrictive and intensive services and actions must be integrated into ongoing services.

1. Continuing this service requires periodic (at least every six (6) months or more frequently, as needed) evaluation by the agency Clinical Director, and approval by the DD Chief Behavior Analyst or designee of the continued likelihood of occurrence of presenting behaviors and progress/benefit in continuing the program and the continuing need for structure and protections provided under this model.
2. An individual may choose to no longer receive this service at any time, or otherwise shall be considered to no longer require this service if the individual has met the clinical objectives identified.
3. This is a transitional service; successful outcome is a reduction of service needs and successful in transition to a less restrictive and intensive level of support within 1-3 years of initiation of ITRH with a maximum time period of three (3) years. Medical necessity must be established annually through the initial and regular review process. If a person's need can't be met within a limit, attempts will be made to locate another funding source or an exception may be approved by the by the director or designee to exceed the limit if exceeding the limit will result in decreased need (units) of one or more other services. The service plan must document exceeding the limit for the service that will result in a decreased need of one or more other services. If it is determined the needs of a significant number of individuals cannot be met within the limitation, an amendment will be requested to increase the amount of the limitation.

Conditions for transition include:

1. The behavioral excesses that made treatment necessary have reduced (especially in the presence of the environmental conditions that previously evoked those behaviors) to levels and intensity that are able to be supported in less intensive service environments.
2. The behaviors intended to replace or occur as an alternative to the problem behaviors now reliably occur in the presence of the environmental conditions that previously evoked those problem behaviors.



3. Support individuals in the identified transition environment have been trained to reliably carry out the medical and behavioral strategies necessary to maintain or continue improvements in health and behavior. These support individuals can implement the strategies without direct supervision from a nurse, behavior analyst or other professional care provider.
4. The recipient no longer requires the levels of oversight established within the intensive services program for professional care providers including physicians, nurses, and behavior analysts.
5. Support individuals are be able to implement strategies of support with supervision levels that are the same as those typically provided in the residential setting to which the person is most likely to move.
6. The ISP team has determined the recommended transition levels of staff across all categories and the physical environment requirements needed for the recipient to maintain or to continue improvements.

When the conditions identified above are met, the recipient no longer requires ITRH treatment, the focus will shift to transition to less restrictive and intensive services and supports while ensuring that the gains made maintain or continue to improve in settings that have more variability in the prevailing contingencies and afford greater access to unplanned, everyday encounters with untrained people.

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

Provider Requirements

An agency must have a DMH contract and have the following:

A Community Residential Facility and a SIL arrangement shall be licensed according to 9 CSR 40-1, 2, 4, 7; 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 at a minimum follow Categories III described above in the group home service of this manual.

IRTH is a specialized facility designed to provide a habilitation environment for persons with intensive and severe maladaptive behaviors or other specialized care needs. The minimum staffing ratio is:

- Staffing—day 1:3, evening 1:3, night 1:6;
- Degreed Professional management—minimum of 2.5 hours per week per each person served; It is expected that the provider will utilize the staffing necessary to meet the needs of the individuals. The ITRH per diem rate is the maximum allowable rate for ITRH services; additional ITRH funding beyond this per diem cannot be requested for a given participant.

Provider Compliance with HCBS Settings Final Rule

IRTH services shall comport fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP which must reflect the following:

- Setting is chosen by the individual and is integrated in, and supports full access to the greater community;



- Opportunities to seek employment and work in competitive integrated settings are being explored;
- Opportunities to 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;
- Documented options based on the person's needs and preferences, and for residential settings, the resources available;
- Individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others;
- Exclusion of unnecessary or inappropriate services and supports;
- All providers of services/supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS;
- Informed consent of the individual in writing and
- Signatures of all individuals and providers responsible.

Designation as an ITRH -The service will be provided by selected residential service providers who have elected to design the system and service to meet the requirements in the new definition and successfully completed the designation process. This will be validated through review of the service system and implementation of the service both prior to including the new service definition on their provider contract and on an ongoing basis once they begin to provide the service to selected individuals who meet the criteria specified.

Provider Designation Process

Designation of a provider as meeting the criteria to be an Intensive Behavioral Residential Provider will be completed by a committee led by the Chief Behavior Analyst or designee in concert with the Region's Behavior Analyst for the Division and the Region's Provider Relations lead. Review of a provider's application will include all related substantiating documentation and onsite observation of staff and systems in action. The provider must meet provider qualifications for this level of service. The facility shall be either a redesign of a currently existing group home or residential services in an ISL.

- 1) Prior to consideration to be an intensive behavioral residential service provider the agency will have demonstrated successful, systematic implementation of Universal strategies via a formal and independent review utilizing the an implementation system tool such as the ASSET (system evaluation of tiered levels of tiered supports) process of the region's Agency Tiered Supports Consultation. Criteria for successful implementation of Universal strategies (these are positive, proactive, strategies that are necessary for improved quality of life for all individuals served):
 - a) The provider will have an established team responsible for planning implementation of a system to develop, train and monitor implementation of universal strategies of support.
 - b) The team with their administration and management's support and assistance will have developed and implemented system to insure fidelity of implementation of these strategies. The system will include oversight via supervisory observation of utilization of the skills by all staff, and
 - c) Data collection with respect to the oversight and observation, re-teaching, and recognition of staff fidelity of implementation of universal strategies.



- d) The team will with their administration and management develop a data system to provide information regarding effectiveness of the universal strategies.
 - e) The team and administration and management will utilize the data to identify problem areas such as situations that frequently are correlated with problem behaviors of one or more individuals or staff frequently involved in incidents with individuals.
 - f) Strategies of system improvement and implementation planning will be developed based on the data collection systems.
- 2) A provider shall be evaluated to meet and to have consistently met the universal strategies implementation requirements above for at least six (6) months prior to application for qualification as an IRTH provider. This will develop the infrastructure and supports to prevent problem behaviors and implement intensive, individualized BSPs with fidelity and consistency.
 - 3) The provider will have a system of quality enhancement and program evaluation such that data is consistently and regularly collected to evaluate policies, procedures, practices and problems including use of physical crisis management procedures. Documentation of the data, review and decisions will be maintained in a systematic manner.
 - 4) All staff working within the intensive behavioral residential program will be competency trained and maintain at least annual recertification in the same approved physical crisis management system.
 - 5) The provider will utilize a process of debriefing within 24 business hours of the use of any physical crisis management procedure or the occurrence of any significant or reportable incident that will include discussion with involved staff, the individual and any observers to the incident to determine what went right, what could be improved and how the situation might be prevented in the future. This discussion of the review will be documented and reviewed in the quality enhancement process.
 - 6) The Program or Clinical Services Director meets the qualifications of a Doctorate Level LBA or Masters Level LBA, under Chapter 337 RSMo. The Program or Clinical Services Director must be in place at the time of designation of the organization as an IRTH provider.
 - 7) Staff responsible for developing behavior analysis services will meet at a minimum the requirements for LBA or Licensed Assistant Behavior Analyst under Chapter 337 RSMo.
 - 8) The ratio of behavior analysts to recipients is no more than one full-time LBA to 20 recipients; or one (1) Licensed Assistant Analyst to 15 recipients with supervision of a LBA to Assistant Analyst ratio of no more than four (4) Assistant Behavior Analysts to one (1) Behavior Analyst.
 - 9) The provider will maintain and make public upon request the statistics related to successful and unsuccessful transitions to less restrictive supports and unsuccessful dischargers. A pattern of unsuccessful discharges in a year will lead to review, corrective action plan and possible termination of designation as an IRTH provider.
 - 10) Continuous demonstration of maintenance of requirements:
 - a) At least annually, providers designated as IRTH providers will undergo recertification as continuing to meet the above criteria and likely to meet the criteria in the upcoming year. This will be completed by the committee (or current members of that committee) that made the initial designation. This review could occur at any time should there be indications of concern (lack of progress of individuals receiving the service, high staff turnover, complaints by guardians or others, etc.).
 - b) If at any time a provider is determined a provider does not meet all of the criteria, a short corrective action plan (less than 60 days to complete) can be developed with the provider and the designating committee and regional director. If services and criteria are not at



criteria at the end of this period the provider will be discontinued as an intensive behavioral residential provider, rates will for service will be adjusted to a rate commensurate with the service level met and if appropriate individuals will be offered the choice of changing to a different provider. If any criteria for discontinuing the Medicaid Waiver agreement or that lead to significant safety concerns are discovered, at any time, appropriate actions will be taken by the Regional Director.

The IRTH 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.

Staff requirements - Include all of the requirements identified under the Group Home service including the following:

All direct-care staff must be 18 years of age and have a HS 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 (1) 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 (5) 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 (5) years of experience and of regional office agreement in the employee’s file.

Clinical Director’s Qualifications include the following:

1. BCBA or Licensed Psychologist or Senior Psychological Examiner.
2. Minimum of three (3) years of experience, post licensure or certification, delivering services to people with dual diagnosis and high risk behaviors, and a Minimum of three (3) years of experience managing and supervising clinical and direct support professionals.

The Clinical Director's responsibilities include the following:

1. Participates in a statewide network to discuss current issues and best practices.
2. Engages in pre-planning activities with mental health, mobile crisis services, and local law enforcement to prepare for crisis situations.
3. Develops individual treatment plans.
4. Evaluates treatment outcomes.
5. Assists in transitioning persons supported from the program to other services and supports.
6. Supervises clinical staff.
7. Facilitates interdisciplinary treatment planning for all persons supported.
8. Implements program of ongoing staff development and training.



9. Ensures integration of and information sharing about ancillary services under the treatment plan, coordination with care managers representing the Medicaid state plan, and independent support coordinators regarding waiver services.
10. Provides orientation to ancillary service providers, physicians, and psychiatrists.

Oversight of this service is provided by the agency Clinical Director who is responsible for ensuring service quality and providing clinical oversight of clinical and direct support staff. Administrative functions are performed by members of the agency management team.

Clinical Director's Qualifications include the following:

- LBA, Licensed Psychologist, or Licensed Clinical Social Worker with specific graduate level training in ABA, or other division approved evidence based intervention strategies.
- Minimum of three (3) years of experience, post licensure or certification, delivering services to people with dual diagnosis and high risk behaviors, and a minimum of three (3) years of experience participating in a clinical team.

Training requirements for Staff:

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 (1) month of the implementation date of the current plan, or within one (1) 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 (3) months of employment).

In addition, the following additional training is required:

- Prior to working with an individual receiving the services, and annually thereafter, receive training on individual specific information including history, health issues and management, psychotropic medications and side effects, specific strategies of support, ISP and individualized treatment plan, data collection, crisis safety plan and other relevant information. This training will be updated in a timely manner as information and strategies change.
- Prior to working, staff who work with the recipient(s) for whom the Intensive Residential Treatment will complete at least 20 contact hours of competency-based instruction with performance-based validation and annual recertification of these skills in the following content areas specific to the treatment approach.
 1. Introduction to ABA and positive behavioral supports – basic principles and functions of behavior, problems with aversive control and common methods of aversive control or coercion.
 2. Providing positive consequences, planned ignoring, and stop-redirect reinforce techniques, relationship developing skills including establishing self as a conditioned reinforcer and as a



motivation operation for desirable behavior by the individual served. (Tools of Choice curriculum and teaching or other approved teaching curricula can be utilized to meet teaching criteria 1 and 2.)

3. Data collection and graphing
4. Demonstration of continued competency in trained skills-100% of staff who may or do come in contact with the individuals served shall be competency trained in an approved physical crisis management system with significant extra emphasis on prevention and de-escalation of crisis.
 - a) There will be an ongoing supervision system that provides for comprehensive monitoring of all staff skills and their implementation of required procedures.
 - b) Monitoring for competence must occur at least once per month for 50 percent of direct service staff that have completed the teaching described above.
 - c) The provider's management system includes measurements of staff competencies for procedures that are required for all staff as well as those included in each individual's treatment plan.

Intensive Therapeutic Residential Habilitation Service Documentation

ITRH 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. 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. Written data shall be submitted to DMH authorizing staff as required.

In addition, ITRH providers must maintain documentation of the following:

- 1) The effectiveness of psychotropic medications quantitatively evaluated for the symptoms the medications are prescribed, and the implementation and effects of the additional interventions designed to lessen the need for such medications.
- 2) Documentation of the quantitative evaluation and collaboration with medical professionals responsible for the medication is the responsibility of the behavioral services provider. The medical professionals prescribing and overseeing medications are responsible for the documentation of the medication regime. Documentation of efforts of ongoing collaboration and utilization of best practices to evaluate need and effectiveness of medications and environmental/behavioral interventions.
- 3) Documentation of the implementation of individual therapeutic strategies which HCBS settings requirements for restrictions if determined necessary including the following:
The following eight (8) requirements must be documented in the person-centered service plan when a modification to the HCBS settings exists:
 1. Identify a specific and individualized assessed need.
 2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
 3. Document less intrusive methods of meeting the need that have been tried but did not work.
 4. Include a clear description of the condition that is directly proportionate to the specific assessed need.



5. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include informed consent of the individual; and
8. Include an assurance that the interventions and supports will cause no harm to the individual

Billing Information: Intensive Therapeutic Residential Habilitation

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Intensive Therapeutic Residential Habilitation	T2016 HK	Day	1 per 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.

In-Home Respite

Available in Comprehensive, Community Support, and MOCDD 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 (other than paid caregivers) normally providing the care. Respite care may not be furnished for the purpose of compensating relief or substituting staff. This service is *not* delivered in lieu of day care for children, nor does it take the place of DH. While ordinarily provided on a one-to-one basis, in-home respite may include assisting up to three (3) individuals at a time. The service is provided in the individual's home or private place of residence. If the service includes overnight care, it *must* be provided in the individual's place of residence. The respite care worker *must* provide supervision of the participant for the duration of the service period, however, sleeping is permitted only when the participant is asleep and only when the service is occurring in the individual's own home. Whether the staff can or cannot sleep during respite in an individual's home *must* be documented in the ISP, specifically documenting the LOC, the individual needs, and if the individual is at risk for elopement or medical issues that require awake staff and specified monitoring. The worker *must* be in close proximity to the participant during sleep periods, although *not* necessarily in the same room.

PA services may be a component of In-home respite as necessary for the individual to participate in the service but may not comprise the entirety of the service.

A unit of service is 15 minutes or one day. The only limitation on the total hours provided is that the hours remain within the overall cost effectiveness of each individual's support plan.

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 MO State professional license such as RN or LPN. State statute RSMo 630.050.

An agency can be a DH, 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 HS 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 (1) 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 (5) 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 (5) 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 (1) month of the implementation date of the current plan, or within one (1) 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 (3) months of employment).

Billing Information: In-Home Respite

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Respite Care, In-Home, Day	S5151	Day	1 unit per day
Respite Care, In-Home, Individual	S5150	15 minutes	40 units per day
Respite Care, In-Home, Group	S5150 HQ	15 minutes	40 units per day



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 - associated with objectives listed in the ISP Written data shall be submitted to DMH authorizing staff as required.

Job Development

Available in Comprehensive, Community Support and PfH Waivers only

Service Description

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

Job Development services are the supports to individuals who, because of the disabilities, will need assistance with obtaining individual competitive or customized employment in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Job Development services may include:

- Application completion assistance with the individual,
- Job interviewing activities with the individual,
- Completion of job analysis and/or task analysis with or without the presence of the individual based upon individualized need,
- Negotiation with prospective employers and education of prospective employers of their role in promoting full inclusion with or without the presence of the individual based upon individualized need.
- Consultation with the prospective employer on the use of assistive technology to promote greater autonomy and independence in the potential workplace,
- Consultation and negotiation of work hours, wages and earnings.

Additional Information about Job Development services:

- Job Development services must be provided in a manner that promotes integration into the workplace and interaction between individuals and people without disabilities in those workplaces while maintaining the individual's rights of dignity, privacy and respect.
- This service and support should be designed to support a successful employment outcome consistent with the individual's assessed goals, needs, interests and preferences. An individual's autonomy and independence to perform employment with the least amount of restrictions must be supported through the person centered planning process.
- Job Development should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual.
- Transportation costs are included in the implementation of Job Development service. Job Development furnished under the waiver may *not* include services available under a program funded under section 110 of the Rehabilitation Act of 1973 and its amendments or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Therefore, the case record for any individual receiving this service *must* document the



individual is *not* eligible for, unable to access, exhausted services or otherwise inapplicable for the aforementioned programs as outlined in an interagency memorandum of understanding between VR and the Division of DD. Job Development can be authorized, without a referral to VR, in those instances when:

- An individual has previously been determined ineligible for VR services or closed unsuccessfully from VR as “disability too severe”.
- An individual has previously accessed VR and their services were discontinued as VR established thresholds of support and/or outcomes were accomplished.

PCA may be provided to support an individual while receiving this service, but may not comprise the entirety of the service.

FFP is *not* claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

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

Service Outcomes Expected:

- The completed job development monthly report describing the job search activities and results of business outreach activities with fidelity; and, any ongoing supports needed to fully secure a job offer in an employment setting of the individuals choosing. The completed monthly report would include a:
 - Summary of additional, amended or modified implementation strategies which maximize competitive integrated employment opportunities, independence, natural supports, career pathways and any identified potential associated risks.
- The completed job placement implementation plan of secured employment to include job title, wages, projected average number of hours to be worked weekly and recommended implementation strategies for paid/natural supports regarding unmet needs (i.e. personal assistance, transportation, skill acquisition, employment onboarding, workplace integration, etc.).

Service Limitations

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

Provider Requirements

This service can be provided by an employment services provider agency. The agency *must* be certified by DMH or accredited by CARF, CQL or Joint Commission, to provide job development services. The agency *must* have a DMH contract and comply with the following training requirements outlined within the contract.

Staff Requirements



Fourteen (14) hours of Division of DD approved training, as outlined in contract, plus an additional six (6) hours of supervised practical mentoring/job coaching related to APSE Supported Employment Service competencies within the first twelve (12) months of hire. Annually thereafter, employees *must* complete four (4) additional hours of Division of DD approved training as outlined in contract. Any staff member who has the following credentials are deemed as meeting all training requirements:

- CESP by passing the national CESP examination from the ESPCC or,
- National Certificate of Achievement in Employment Services from the ACRE.
- Direct Support Professional-Specialist-Employment Support credentialing issued by the NADSP.

Billing Information: Job Development

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Job development, Individual	H0038	15 minutes	32 units per day, 240 units per year

Job Development Service Documentation

Providers of Job Development *must* maintain an individualized plan and detailed record of activities by unit of service. The provider is required to follow procedures set forth under The Code of State Regulations 13 CSR 70-3.030, which defines adequate documentation.

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. Job Development has implementation elements which do *not* require an individual be present. Duplicative billing applies only to those services where an individual is concurrently receiving "in-person" services during the same unit of time. As such, billing could occur during shared units of time with appropriate documentation.

Providers of all these services *must* maintain an individualized plan and detailed record of activities by unit of service. The provider is required to follow procedures set forth under the Code of State Regulations 13 CSR 70-3.030, which defines adequate documentation. ISP's will include outcomes/goals, with criteria, and will be supported by data to demonstrate progress and implementation strategies that optimize autonomy and independence.

Providers *must* maintain service documentation described in Section C of the DD Waiver Manual, including detailed progress notes per date of service and monthly progress notes associated with objectives.

Occupational Therapy

Available in Comprehensive, Community Support, and PfH Waivers only

Service Description



OT requires prescription by a physician and evaluation by a certified (OT). The service includes evaluation, plan development, direct therapy, consultation and training of caretakers and others who work with the individual. A certified occupational therapeutic assistant (COTA) may provide direct therapy services under the supervision of an OT. 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 MO license number.

OT 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. The OT services are limited to additional services not otherwise covered under the state plan, including EPSDT but consistent with waiver objectives of avoiding institutionalization. Children have access to any medically necessary preventive, diagnostic, and treatment services under EPSDT services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities. OT needs for the eligible person through EPSDT, as applicable, shall be accessed and utilized, in accordance with the requirement that state plan services *must* be exhausted before waiver services can be provided. OT services authorized through the waiver *must not* duplicate state plan services.

When providing OT services via telehealth, please refer to Section G: Telehealth Services in this manual for additional requirements.

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 OT by American Occupational Therapy Association (AOTA) or registered as a COTA. An OT *must* be either certified as an OT by the AOTA or registered as a COTA. Requirements for registration as a COTA in MO 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 OTs may also employ registered COTAs supervised by licensed OTs who are certified according to RSMo 1990 334.735—334.746 as OT by AOTA or registered as a COTA. An OT *must* be either certified as an OT by the AOTA or registered as a COTA. Requirements for registration as a COTA in MO 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



Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Occupational Therapy	97535	15 minutes	8 units per day
Occupational Therapy, COTA	97535	15 minutes	8 units per day
Occupational Therapy, Consultation	97535	15 minutes	8 units per day

Occupational Therapy Service Documentation

OT 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 OT or 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, Community Support, and MOCDD 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, stand-alone facility or Shared Living Host Home Relief/Relief Home 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.

Service Limitations

Out of Home Respite is a service used on a short-term basis because of the absence or need for relief of those persons who normally provide care for the individual. Out of home respite is limited to no more than 60 days annually, unless a written exception is granted from the Regional Office Director or designee. The 60 days may be consecutive, unless the service is provided in an ICF/ID or State Habilitation Center. Out of home respite provided in an ICF/ID or State Habilitation Center cannot exceed 30 days. The total limit of out of home respite is six (6) months. Any settings where individuals will be served for over 60 days must comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5). The Out of Home Respite service is a temporary service and requires a hard limit to the exception amount. This will not affect section 9817 of ARP.

A host home provider shall *not* provide out-of-home respite if there is an individual currently residing in the home and receiving host home services. A host home provider may provide out of home respite services if there is not currently an individual residing in the home and receiving host home services.

Provider Requirements

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



A Group Home 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.

A Shared Living Host Home /Relief Home shall be certified according to 9 CSR 45-5.010-060; or accredited by CARF, CQL or Joint Commission

A Stand-alone Respite Facility shall be certified according to 9 CSR 45-5.010-060; or accredited by CARF, CQL or Joint Commission

Staff Requirements

All direct-care staff *must* be 18 years of age and have a HS 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 (1) 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 (5) 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 (5) 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 (1) month of the implementation date of the current plan, or within one (1) 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 (3) months of employment).

Billing Information: Out of Home Respite

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Respite Care, Out-of-Home, Day	H0045	Day	1 unit per day
Respite Care, Out-of-Home	H0045	15 minutes	(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 associated with objectives listed in the ISP. Written data shall be submitted to DMH authorizing staff as required.

Person Centered Strategies Consultation

Person Centered Strategies Consultation was removed from all the waivers with dates of service on or after March 1, 2021.

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. PCSC 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. This is *not* a direct therapy type service, for example the consultant's interaction with the individual should be pleasant and positive, but it is *not* this interaction that improves the quality of the person's life, rather the changes made to the person's support system, especially those focusing on implementation of identified strategies make the difference for the individual.

PCSC 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 one-fourth hour. This is a short term service that is *not* meant to be on going, the typical duration of service is to be twelve (12) months or less.

This service is *not* to be provided for development or implementation of BSPs or functional assessment as these services require licensure as a behavior analyst, psychologist, counselor or social worker with specialized training in ABA. However, this service might work in conjunction with an ABA 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 ABA 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 ABA.

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 ISP to ensure the implementation of the new strategies with fidelity and consistency by the support team after the PCSC is completed.

Psychology/Counseling services under EPSDT do *not* include PCSC.

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 PCSC. A PCSC 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 ABA 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 Consultation

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Person Centered Strategies Consultation	H0004 HK	15 minutes	32 units per day

Person Centered Strategies Consultation 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.

Personal Assistant

Available in all Waivers

Service Description

PA services include a range of assistance for any ADL or IADL to enable individuals to complete tasks they are not able to do for themselves due to their disability. This may take the form of hands on assistance (actually performing a task for the individual), cueing to the individual to perform a task, or performing the task for the individual if they are not able to do for themselves. PA services provide support and incidental teaching to assist the individual to participate fully in their home and community life. These supports can be provided in the participant's own home, family home, and in the community, and always provided in the presence of the individual.

While PA service is ordinarily provided on a one-to-one basis, personal assistance may be delivered to groups of individuals when it is determined to meet the individuals' needs. With written approval from the Regional Office Director, PA services may be delivered to groups of four (4) to six (6) persons when it is determined the needs of each individual in the group can be safely met.

PA staff are required to be awake at all times. PA Services may be provided on an episodic or continuing basis. PA Services may be provided by an agency or as a self-directed option.

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 agency-based PA services, team collaboration is included in the unit rate.

Personal Assistant, Self-Directed option

Self-Directed Supports is an option of service delivery for individuals who wish to exercise more choice, control and authority over their supports.



Team Collaboration, Self-directed option

Team collaboration is available under Self-Directed Services only. 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 DR 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 limited to 120 hours per plan year. Team collaboration is included in the rate for agency-based PA services.

Relatives as Providers

Relatives (parent, step-parent, foster parent, sibling, child (by blood, adoption, or marriage), spouse, grandparent, or grandchild) may be approved to provide PA services through an agency or self-directed with exceptions listed below.

The following cannot be a provider of PA services:

- Individual's spouse;
- Parent, step-parent, or foster parent of a minor child (under age 18);
- The individual's guardian;
- Self-directed supports DR or employer of record.

When a relative provides personal assistance, the ISP must reflect:

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

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

Family members approved to provide PA services may be employed by an agency or employed by the individual/guardian or DR using an approved FMS provider. If the person employs his/her own workers using an approved FMS provider, the family member serving as a paid PA also shall *not* be the DR/common law employer.

Difference between State Plan Personal Care and DD Waiver Personal Assistant Services

PA Service under the waiver differs in scope, nature, supervision arrangements, limitation of amount, and/or provider type from personal care services in the State Plan.

PA Services differ from State Plan in the following ways:

- PA may be provided in the community.
- PA must always be provided in the presence of the individual receiving the service.
- PA can provide support with medication administration and management. (PA, Medical, unless self-directed).



- PA can provide specialized healthcare and medical tasks or tasks requiring nursing delegation (PA, Medical, unless self-directed).
- PA may be self-directed through the use of a DR.

When an individual's need for PA service can be met through the MO HealthNet state plan personal care program administered by the Division of Senior and Disability Services (DSDS) with the MO DHSS, he or she will not be eligible for PA Services under the waiver, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided.

After State Plan Personal Care Services have been exhausted, DD Waiver PA 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;
- The individual has medical needs and they require a more highly trained PA than is available under state plan;
- When the PA worker is related to the individual ; or
- When the individual or family is directing the service through the Vendor Fiscal Employer Agent (VF/EA) Financial Management Services (FMS) contractor.

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

9 CSR 45-3080(9) states: Consumer-Directed Personal Assistance Program through the DHSS. Individuals who receive services under the consumer-directed personal assistance program authorized in 19 CSR 15 Chapter 8 and administered by DHSS may *not* simultaneously use SDS under any HCB waiver operated by the Division of DD. Individuals eligible to self-direct supports under both the DHSS consumer-directed personal assistance program and under an HCB waiver operated by the Division of DD *must* choose which program to direct supports under and choose a qualified provider of agency-based supports for the other.

Personal care services are provided to children with disabilities according to the federal mandates of the EPSDT program. PA 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 utilized before waiver services can be provided. PA services authorized through the waiver shall *not* duplicate state plan personal care services. State plan personal care services for children are coordinated through the BSHCN.

When waiver PA 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

PA services shall *not* duplicate other services. Personal assistance is *not* available to waiver individuals who reside in community residential facilities (Group Homes and Residential Care Centers).



RCF and ALF facilities licensed by the DHSS are qualified providers of state plan personal care. MO state law requires RCFs and ALFs to provide assistance with ADL's and assistance with IADL's 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. PA services can occur in the person's home and/or community, including the work place. PA services shall *not* be provided concurrently, with or as a substitute for, facility-based DH services. A participant's support plan may include two (2) 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.

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

Service Limitations

- Individuals who receive Group Home, ISL, or Shared Living may not receive Personal Assistance as it is already a component of the Group Home, ISL and Shared Living service.
- When this service is provided to minor children living with their parents or guardians, it shall *not* supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally-related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the individual's need for the service as an alternative to institutional care and the overall cost effectiveness of his or her support plan. PA services can occur in the person's home and/or community, including the work place. PA services shall *not* be provided concurrently, with or as a substitute for, facility-based DH services.
- PA services through EPSDT for eligible persons under age 21 shall be provided and utilized first before the waiver PA service is provided. Children have access to any medically necessary preventive, diagnostic, and treatment services under EPSDT services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.
- The services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
- The services to be provided are solely for the individual (not household tasks expected to be shared with people living in the family unit).



Provider Requirements

PA services can be self-directed if the individual chooses.

This service can also be provided by an agency or an individual contractor. An agency can be a DH or an ISL services provider. A DH or ISL provider *must* be certified by DMH or accredited by the CARF, The CQL or Joint Commission. An agency may also be a MO HealthNet enrolled provider of personal care services. The agency-based provider of PA services *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 plan.

An individual may be an independent contractor who *must* have a MO State professional license such as RN or LPN. The independent contractor *must* have a DMH contract and shall *not* be the individual's spouse, a parent of a minor child (under age 18), nor a legal guardian.

PA services can be self-directed if the individual chooses. An employee of the individual/family *must* be age 18, has completed Abuse and Neglect training/reporting events and training on the ISP, meets minimum training requirements; and has an agreement with the individual/DR. The planning team will specify the qualifications and training the PA will need in order to carry out the support plan. Supervision is provided by the individual or a DR in providing service in the home or community consistent with the support plan.

A relative employed by individual/family *must* be age 18, has completed Abuse and Neglect training/reporting events and training on the ISP, meets minimum training requirements, and has an agreement with the individual/DR. The relative shall *not* be the individual's spouse, a parent of a minor child (under age 18), a legal guardian, nor the employer of record for the individual. The individual shall *not* be opposed to the family member providing care. The planning team agrees the family member providing the PA service will best meet the individual's needs. Family members employed by the individual or DR are supervised by the individual or a DR in providing service in the home or community consistent with the support plan. Family members employed by an agency are supervised by the agency.

In accordance with the 21st Century CURES Act and 13 CSR 70-3.320, effective January 1, 2020 providers are required to utilize an electronic visit verification (EVV) system to document services rendered related to the delivery of in-home services for all Medicaid-funded agency and self-directed personal care services. Home and Community Based service PA providers and the self-directed FMS Provider shall have an EVV system in place. It is the responsibility of each provider to ensure the accuracy of all data transmitted via EVV and to report any suspected falsification of data to the MMAC Unit. Providers who are found to be out of compliance with EVV are subject to sanctions to participation in the MO HealthNet program.

Staff Requirements

All direct-care staff *must* be 18 years of age and have a HS 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 (1) 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 (5) 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 (5) years of experience and of regional office agreement in the employee’s file.

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

Training will cover, at a minimum:

- Training, procedures and expectations related to the PA in regards to following and implementing the ISP;
- 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 TCM 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 abuse/neglect, event reporting, and confidentiality;
- Duties of the PA will not require skills to be attained from the training requirement;
- CPR and first aid;
- Additionally staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
- Crisis Intervention Training (CIT), as needed, due to challenging behavior by the individual, and the assistant will also be trained in crisis intervention techniques such as Nonviolent Crisis Intervention(NCI), MANDT, or others approved by the Division of DD);
- Training in communications skills in understanding and respecting individual choice and direction, cultural and ethnic diversity, personal property and familial and social relationships in handling conflict and complaints; and
- Training in assisting with ADL’s and IADL, as needed by the individual to be served and identified by the team.

For SDS, the planning team will specify the qualifications and training the PA will need in order to carry out the support plan, where and by whom the assistant will be trained, and the source, method and degree of monitoring but not less than quarterly. To the extent they desire, the individual or DR will select the PA and carry out training and supervision.

The individual/guardian or DR may exempt the PA from trainings when the following is documented:

- Duties of the PA will not require skills to be attained from the training requirement;
- The PA has adequate knowledge or experience in the training subjects listed below:
 - CPR and first aid;
 - Medication administration;



- CIT, as needed, due to challenging behavior by the individual, the assistant will also be trained in crisis intervention techniques such as NCI , MANDT, or others approved by the Division of DD;
- Training in communications skills, in understanding and respecting individual choice and direction, cultural and ethnic diversity, personal property and familial and social relationships, in handling conflict and complaints; and
- Training in assisting with ADL's and IADL's, as needed by the individual to be served and identified by the team.

Medical Personal Assistance (Agency or Self-Directed)

To assist in meeting the specialized medical needs for the individual as identified by the team and documented in the ISP the following requirements *must* be met to:

- The interdisciplinary team has identified and outlined the need to pursue more intensive support for medically related issues;
- The need must be documented by a physician or advanced practice nurse and maintained on file;
- Prior to approval of funding for medical PA the ISP must undergo the local UR review process to determine the above have been completed;
- Depending upon the scope of services, a Registered Professional Nurse may be required to provide oversight in accordance with the Missouri Nurse Practice Act.

The specialized medical PA *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 SDS, the specialized medical PA shall *not* be exempt from the following:

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

For individuals hospitalized, PA services may be provided to assist with supports, supervision, communication, and any other supports that the hospital is unable to provide. The service will: be identified in an individual's person-centered service plan; provided to meet needs of the individual that are not met through the provision of hospital services; not substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and be designed to ensure smooth transitions between acute care settings and HCB settings, and to preserve the individual's functional abilities.

Billing Information: Personal Assistance

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
PA Individual, Self-Directed	T1019 U2	15 minutes	96 units per day



PA Agency/Contractor	T1019	15 minutes	96 units per day
PA, Group Size 2-3	T1019 HQ	15 minutes	96 units per day
PA, Group Size 4-6	T1019 HQ	15 minutes	96 units per day
PA, Medical, Agency/Contractor	T1019 SC	15 minutes	96 units per day
PA, Medical, Self-Directed	T1019 SC SE	15 minutes	96 units per day
Hospital Supports for all PA is Place of Service "21"		15 minutes	96 units per day

Personal Assistant Documentation

PA 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.

Accrual of Minutes

A unit of PA service is 15 minutes. Effective for dates of service on and after April 1, 2020, it is permissible to accrue partial units of less than 15 minutes for several dates of service and bill the total, in whole units (15 minutes), at the end of the day, week, or month as long as the service delivery is consistent with the written plan of care in the ISP. For example, a provider delivers care from 10:00 AM to 2:05 PM on June 1, then provides care from 10:00 AM to 2:10 PM on June 2. Sixteen units of services are billed for June 1, and 17 units of services are billed on June 2. Providers are required to reference all partial units that add up to the 15 minute unit billed. Partial units may only be accrued during the same calendar month and may not be carried over and accrued in a different calendar month. When billing multiple dates of service on one detail line of a claim, total the time spent in minutes for each date, divide by 15, and bill the number of whole units. Do not round up to the nearest whole unit. For example, at the end of the month, time spent in the provision of personal care to an individual who received services every day, totals 620 minutes. $620/15=41.33$ units. Bill for 41 whole units of service. When billing multiple dates of service on one detail line of a claim, dates during which the client is in a hospital, in a nursing home facility, visiting relatives or is ineligible should *not* be included in the range of dates. When billing multiple dates of service on one detail line of a claim, do not bill for dates of service falling in two separate calendar months.

Physical Therapy

Available in Comprehensive, Community Support and Pfh Waivers only

Service Description

PT 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.

PT requires a prescription by a physician and evaluation by a certified PT. The service includes evaluation, plan development, direct therapy, consultations and training of caretakers and others who work with the individual. A certified physical therapeutic assistant (CPTA) may provide direct therapy services under the supervision of a PT.

This service may include clinical consultation provided to individuals, parents, primary caregivers, and other programs or habilitation services providers.



A unit of service is 15 minutes.

When providing PT services via telehealth, please refer to Section G: Telehealth Services in this manual for additional requirements.

Service Limitations

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.

PT needs for the eligible person through EPSDT, as applicable, shall be accessed and utilized, in accordance with the requirement that state plan services *must* be utilized before waiver services can be provided. PT services authorized through the waiver shall *not* duplicate state plan services. PT services are limited to additional services not otherwise covered under the state plan, including EPSDT but consistent with waiver objectives of avoiding institutionalization. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's EPSDT services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities. The service provider *must* document the identity of the PT, including full name and MO license number.

Provider Requirements

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

Billing Information: Physical Therapy

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Physical Therapy	97110	15 minutes	8 units per day
Physical Therapy, Consultation	97110	15 minutes	8 units per day

Physical Therapy Service Documentation

PT 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.

Prevocational Services

Available in Comprehensive, Community Support, and PfH Waivers only

Service Description

Prevocational Services provide one-to-one learning and group experiences to further develop an individual's general, non-job task specific skills needed to succeed in competitive, integrated



employment (work settings where compensation is at or above minimum wage). Services are expected to occur over a defined period of time with specific and measurable outcomes to be achieved.

Services prepare the individual to attain the highest level of independence and autonomy in the most integrated employment setting aligned with the individual's interests, abilities, and capabilities.

Prevocational services includes activities that are primarily directed at assisting an individual with developing non-job task specific skills that are associated with performing competitive work in community integrated employment. Providers of this service may coordinate, evaluate and communicate not only with the individual but, also with community businesses to develop unpaid work experiences. This service should be provided in the presence of the individual to the maximum extent possible and should be conducted in the community to the maximum extent possible but completion of activities without the presence of the individual should *not* be precluded.

Prevocational services may include volunteering, uncompensated work experience and compensated work experience settings to support the development of expanded habilitation skills. Any limitations on location or duration of these experiences are established and governed through the US DOL Fair Labor Standards Act and Wage and Hour Laws. It is the service provider's responsibility to understand these industry specific term and act in accordance to DOL regulations.

Services may be provided in a community setting or at a certified or accredited facility of a qualified employment service provider. The setting for the delivery of services must be aligned with the individualized assessed need and that which is most conducive in developing the specific and measurable outcomes contained within the ISP. Services cannot be provided within an individual's residence.

Services are intended to develop and teach expanded habilitative skills that lead to competitive and integrated employment including, but *not* limited to:

- Communication with supervisors, co-workers and customers;
- Workplace appropriate conduct, hygiene and dress;
- Workplace problem solving skills;
- Use of strategies, to include assistive technology, for task attendance and completion;
- Workplace safety skills;
- Mobility and motor skills training and
- Asset development and financial literacy

Vocational services, which are not covered through home and community based waivers, are job task specific skills training required by a participant for the primary purpose of completing those tasks for a specific facility based job or those delivered in a segregated setting. The distinction between vocational and pre-vocational services is that Prevocational Services are delivered for the purpose of furthering habilitation goals that will lead to greater opportunities for competitive integrated employment or further career advancement.

Participation in Prevocational Services is *not* a pre-requisite for supported employment services. Prevocational services should only be authorized when an individual is otherwise unable to directly



enter the general workforce as a result of an underdeveloped or undeveloped general, non-job-task-specific skill(s).

Prevocational services can be provided in small groups *not* exceeding four (4) individuals at a time. The decision to provide services in a group setting *must* be based on individualized assessed need and be supported in the person centered plan as being the most autonomous setting which facilitates the highest levels of individual learning.

The provision of Prevocational Services is always delivered with the intention of developing skills which will lead to competitive integrated employment. Volunteering for personal reasons not related to future employment would not be Prevocational Services.

- All prevocational service options should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual.
- These services and supports should be designed to support successful employment outcomes consistent with the individual's goals.
- PA services may be a component of Prevocational service as necessary for the individual to participate in the service but may not comprise the entirety of the service.
- Transportation costs for implementation of Prevocational Services are included in the unit rate.
- Individuals who receive prevocational services may also receive supported employment and/or DH services. A participant's person-centered support plan may include two (2) 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, unless specifically permitted under the service definition.
- Prevocational Services furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 and its amendments or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Therefore, the case record for any individual receiving this service must document the individual is not eligible for, unable to access, exhausted services or otherwise inapplicable for the aforementioned programs as outlined in an interagency MOU between VR and the Division of DD
- Prevocational services must comply with 42 CFR §440.180I (2) (i).

Outcomes expected for this service are as follows:

1. Identification of the skills being developed.
2. Actions steps and planning to include a timeline and steps necessary to achieve the outcome by unit of service.
3. Progress measures on the skills being developed for the outcome(s) identified.
4. Providers of Prevocational Services must maintain an individualized plan and detailed record of activities by unit of service

Service Limitations

Must be authorized based upon individual need *not* to exceed 2,080 units per annual support plan year. Additional units *must* be pre-authorized by the Division's Regional Director or designee.



Provider Requirements

This service can be provided by an employment services provider agency. The agency *must* be certified by DMH or accredited by CARF, CQL or Joint Commission, to provide Prevocational services. The agency *must* have a DMH contract and comply with training requirements outlined within the contract.

Staff Requirements

All direct-care staff *must* be 18 years of age and have a HS 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 (1) 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 (5) 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 (5) 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 (1) month of the implementation date of the current plan, or within one (1) 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 (3) months of employment).
- Fourteen (14) hours of Division of DD approved training, as outlined in contract, plus an additional six (6) hours of supervised practical mentoring/job coaching related to APSE Supported Employment Service competencies within the first twelve (12) months of hire. Annually thereafter, employees must complete four (4) additional hours of Division of DD approved training as outlined in the contract. Any staff member who has the following credentials are deemed as meeting all training requirements:
 - CESP by passing the national CESP examination from the ESPCC or,
 - National Certificate of Achievement in Employment Services from the ACRE.
 - Direct Support Professional-Specialist-Employment Support credentialing issued by the NADSP.

Billing Information: Prevocational Services

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
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Pre-vocational Services, Individual	H2025	15 minutes	32 units per day, 2080 units per annual support plan year
Pre-vocational Services, Group	H2025 HQ	15 minutes	32 units per day, 2080 units per annual support plan year

Prevocational Services Service Documentation

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.

Providers of all these services *must* maintain an individualized plan and detailed record of activities by unit of service. The provider is required to follow procedures set forth under The Code of State Regulations 13 CSR 70-3.030, which defines adequate documentation.

ISP's will include outcomes/goals, with criteria, and supported by data to demonstrate progress and on which to based changes in strategy.

Providers *must* maintain service documentation described in Section C of the DD Waivers Manual, including detailed progress notes per date of service and monthly progress notes associated with objectives.

Professional Assessment and Monitoring

Available in Comprehensive, Community Support, and PfH Waivers

Service Description

Professional Assessment and Monitoring (PAM) is intended to promote and support an optimal level of health and well-being. A prescribing practitioner must prescribe an identified need for the PAM service. PAM is a consultative service by a licensed health care professional that may be utilized to assess, examine, evaluate, and/or treat an individual's identified condition(s) or healthcare needs and planning and may include instructions and training when identified as needed for the care of the individual. PAM services maintain, restore and/or improve an individual's functional status. PAM may include ancillary, management and/or instructional strategies. PAM providers are to coordinate and communicate with the individual, their caregivers and the support team. All changes in health status are to be communicated to the physician and the support coordinator. Written reports of the visit will be provided to the support coordinator. All services *must* be documented in the individual record.

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 LPN under the supervision of a RN, or a licensed dietitian to the extent allowed by their respective scope of practice in the State of MO.

PAM may be utilized but is not limited to:



- a) Evaluate care needs; an example would be a visit to determine whether the desired outcomes have been met or how well the plan of care is working and if the plan of care needs to be modified.
- b) Plan appropriate supports including instructions for caregivers; an example would be staff training related to a disease or condition such as seizure precautions or recognizing reportable signs and symptoms.
- c) Complete a physical assessment of condition; an example would be assessing a worsening of a chronic condition or an acute change in health or functional status.
- d) Assess the care environment; an example would be to assess the ability of the individual to safely access their environment and the need for minor changes and /or a referral to an OT/PT for environmental adaptation or change.
- e) Set up medications; an example would be dispensing medications in a pillbox or other container for one to administer.
- f) Administer injections; an example would be administering a monthly vitamin or hormone injection.
- g) Perform complex nursing treatments; an example would be assessing and suctioning the airway or dressing a wound that requires evaluation of healing and absence of complications.
- h) Assess nutritional needs, diet restrictions and current health plans to develop and implement complete nutritional care plans; an example may be evaluating caloric needs if overweight or underweight, food allergies, dietary modifications and /or supplementation.
 - i. Complete nutrition counseling (beyond standard medical management); an example may be to address medical issues or provide specialist services specific to disease.
 - ii. Provide nutritional services; an example may be working in consultation with the physician or other health care providers to provide specific nutritional needs to consumers unable to consume food normally.
 - iii. Provides nutritional education to individuals and groups; an example may be advising individuals and their families on basic rules of good nutrition, healthy eating habits, and nutrition monitoring to improve their quality of life and /or nutritional principles, dietary plans, diet modifications, food selection and preparation.

Providers of PAM *must* maintain an individualized plan of treatment and detailed record of intervention activities by unit of service. The provider is required to follow procedures set forth under The Code of State Regulations 13 CSR 70-3.030, which defines adequate documentation.

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 [Physician's Program](#) in 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. PAM is not continuous care.

The PAM service is limited to additional services not otherwise covered under the state plan, including EPSDT but consistent with waiver objectives of avoiding institutionalization. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's EPSDT services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to



improve and maintain the ability of the child to remain in and engage in community activities. Children under the age of 21 may be eligible and qualify for private duty nursing under the Medicaid State plan.

Staff Requirements

Service provider *must* be licensed in MO as a RN, LPN, or Dietician.

Provider Requirements

PAM service providers *must* have a valid DMH contract and/or provide services through an OHCDS 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

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Professional Assessment and Monitoring, Registered Nurse	T1002	15 minutes	48 units per day
Professional Assessment and Monitoring, Licensed Practical Nurse	T1003	15 minutes	48 units per day
Professional Assessment and Monitoring, Dietician	S9470	15 minutes	48 units per day

Professional Assessment and Monitoring Service Documentation

PAM 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.

All services *must* be adequately documented in the individual record. The Code of State Regulations 13 CSR 70-3.030 section (A)(2) defines –adequate documentation and adequate medical records as follows: adequate documentation means documentation from which services rendered and the amount of reimbursement 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 health services such as personal care and home services.

Shared Living

Available in Comprehensive waiver only

Service Description

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



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

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

Host Home and Companion services include the following:

- a) Basic personal care and grooming, including bathing, care of the hair and assistance with clothing;
- b) Assistance with bladder and/or bowel requirements or problems, including helping the individual to and from the bathroom or assisting the individual with bedpan routines;
- c) Assisting the individual with self-medication or provision of medication administration for prescribed medications, and assisting the individual with, or performing health care activities;
- d) Performing household services essential to the individual's health and comfort in the home (e.g. necessary changing of bed linens or rearranging of furniture to enable the individual to move about more easily in his/her home);
- e) Assessing, monitoring, and supervising the individual to ensure the individual's safety, health, and welfare;
- f) Light cleaning tasks in areas of the home used by the individual;
- g) Preparation of a shopping list appropriate to the individual's dietary needs and financial circumstances, performance of grocery shopping activities as necessary, and preparation of meals;
- h) Personal laundry;
- i) Incidental neighborhood errands as necessary, including accompanying the individual to medical and other appropriate appointments and accompanying the individual for short walks outside the home;
- 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.
- k) Transportation is included in the Shared Living rate.



Payment to the host or companion home is a flat monthly rate to meet the individual's support needs, and is exempt from income taxes. The Host Home will be paid on the basis of intensity and difficulty of care. The rate methodology is described in the waiver application.

Depending on the needs and compatibility of the individuals, no more than three (3) individuals, regardless of funding source, may choose to live in the same-shared living location. Funding sources could include Waiver, private pay, Children's Division foster care, etc. Individuals receiving host home services and sharing a home with housemates shall each have a private bedroom, unless they choose otherwise.

For individuals hospitalized, staffing supports normally provided through Shared Living services may be provided to assist with supports, supervision, communication, and any other supports that the hospital is unable to provide. The service will: be identified in an individual's person-centered service plan; provided to meet needs of the individual that are not met through the provision of hospital services; not substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and be designed to ensure smooth transitions between acute care settings and HCB settings, and to preserve the individual's functional abilities.

Limitations

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

The Shared Living service includes components of PA, ISD and CN within the service implementation; therefore PA, ISD and CN services cannot be authorized in addition. PA, ISD and CN are already components of Shared Living service and funded under the Shared Living service.

Payments for Shared Living do *not* include room and board, items of comfort or convenience, or the costs of home maintenance, upkeep, and improvement. Individuals who receive Shared Living 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 certified according to 9 CSR 45-5.010-.060. They can also be accredited through CARF, CQL, or Joint Commission.

Billing Information: Shared Living

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Shared Living (Host/Companion Home)	S5136	Day	1 unit per day
Hospital Supports	S5125	15 minutes	96 units per day

Shared Living Service Documentation



Shared Living 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.

Specialized Medical Equipment and Supplies (Adaptive Equipment) **Available in all Waivers**

Service Description

SME includes devices, controls, or appliances, specified in the support plan, which enable individuals to increase their abilities to perform ADL's, or to perceive, control, or communicate with the environment in which they live.

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.

Incontinence supplies for children and youth ages 4 through 20 with disabilities or special health care needs are covered under MO HealthNet through the EPSDT program. Incontinence supplies for participants 21 and over are covered through MO HealthNet Exceptions process, excluding participants of the Community Support, Comprehensive or Partnership for Hope Waivers.

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 EAA and SME 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.

Service Limitations

Costs are limited to \$7,500 per annual support plan year, per individual for all Waivers. If a person's need can't be met within a limit, attempts will be made to locate another funding source or an exception may be approved by the by the director or designee to exceed the limit if exceeding the limit will result in decreased need (units) of one or more other services. The service plan *must* document exceeding the limit for the service that will result in a decreased need of one or more other services. If it is determined the needs of a significant number of individuals cannot be met within the limitation, an amendment will be requested to increase the amount of the limitation.

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. These services are limited to additional services not otherwise covered under the



state plan, including EPSDT but consistent with waiver objectives of avoiding institutionalization. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's EPSDT services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service are to improve and maintain the ability of the child to remain in and engage in community activities. 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 DME 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 DME that require fitting, set-up, and/or instructions, a provider cannot bill prior to providing proper set-up, fitting and instruction for items of DME 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 DME Provider or currently possess a DMH contract to provide any other DD waiver service.

Billing Information: Specialized Medical Equipment and Supplies

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Spec. Medical Equipment and Supplies	T2029	1 Job	1 job per month/ \$10,000 per annual support plan year

Specialized Medical Equipment and Supplies Service Documentation

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



Speech Therapy

Available in Comprehensive, Community Support, and PfH Waivers only

Service Description

Speech Therapy (ST) 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 (ST) 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 ST. The need for services *must* be identified in the support plan and prescribed by a physician. ST 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 MO as a ST. 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 STs *must* receive periodic, routine supervision from their employer, a Medicaid waiver enrolled ST 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 ST. Services *must* be required in the support plan 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 MO license number.

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

ST needs for the eligible person through EPSDT, as applicable, shall be accessed and utilized, in accordance with the requirement that state plan services *must* be exhausted before waiver services can be provided. ST services authorized through the waiver shall *not* duplicate state plan services. Children have access to EPSDT services. The services are limited to additional services not otherwise covered under the state plan, including EPSDT but consistent with waiver objectives of avoiding institutionalization. Children have access to any medically necessary preventive,



diagnostic, and treatment services under EPSDT services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service are to improve and maintain the ability of the child to remain in and engage in community activities.

When providing ST services via telehealth, please refer to Section G: Telehealth Services in this manual for additional requirements.

Provider Requirements

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

Billing Information: Speech Therapy

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Speech Therapy	92507	15 minutes	8 units per day
Speech Therapy, Consultation	92507	15 minutes	8 units per day

Speech Therapy Service Documentation

ST 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 ST 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 I&A to the individual for the purpose of self-directing supports. This includes practical skills training and providing information on recruiting and hiring PA workers, managing workers and providing information on effective communication and problem-solving. The extent of the assistance furnished to the individual or DR is specified in the ISP.

A Support Broker provides the individual or their DR with I&A to secure the supports and services identified in the support plan.

A Support Broker provides the individual or DR with I & A to:

- Establish work schedules for the individual's employees based upon their support plan;
- Help manage the individual's budget and employee rate setting;
- Seek other supports or resources outlined by the support plan;



- Define goals, needs and preferences, identifying and accessing services, supports and resources as part of the person centered planning process which is then gathered by the support coordinator for the support plan;
- Assist in navigating IDS;
- 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/ DR to managing services and supports;

Support Broker services do *not* duplicate Support Coordination. Support Brokerage is a direct service.

Service Limitations

A Support Broker shall *not* be a parent, guardian or other family member. A Support Broker cannot serve as a self-directed PA for that individual. This service can be authorized for up to 32 units per day (8 hours).

Provider Requirements

An agency *must* have a DMH contract.

For an agency to provide this service it has to be certified by DMH Certification for ISL, CN or DH; or accredited by CARF/CQL/Joint Commission accredited for ISL or, CN or DH that employs qualified Support Brokers.

Support Brokers *must* have a background screening per the Division of DD, be at least 18 years of age and possess a HS 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/DR in the specific areas of support as described in the support plan;
- Competence in knowledge of Division of DD policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Understanding of Support Broker responsibilities, of advocacy, person-centered planning, and community services;
- Understanding of individual budgets and Division of DD fiscal management policies.
- The planning team may specify any additional qualifications and training the support broker will need in order to carry out their duties as specified in the Support Plan.

Billing Information: Support Broker

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Support Broker, Agency	T2041	15 minutes	32 units per day



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.

Supported Employment

Available in Comprehensive, Community Support and PfH Waivers only

Service Description

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

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

Assistance for self-employment may include:

- Aide to the individual in identifying potential business opportunities;
- Assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; and
- Identification of the supports that are necessary for the individual to operate the business.
- Ongoing assistance, counseling and guidance once the business has been launched.

Supported Employment- Individual Supported Employment:

Individual Supported Employment services are the ongoing supports to individuals and their employers who, because of their disabilities, need intensive on-going support to maintain a job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported Employment – Individual Supported Employment services may include:

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



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

Supported Employment – Small Group Employment Support:

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

Supported Employment – Small Group Employment Supports may include:

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

Additional Information about Supported Employment services:

- Supported employment services must be provided in a manner that promotes integration into the workplace and interaction between individuals and people without disabilities in those workplaces while maintaining the individual's rights of dignity, privacy and respect.
- All Supported Employment service options should be reviewed and considered as a component of an individual's person centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual.
- These services and supports should be designed to support successful employment outcomes consistent with the individual's assessed goals, needs, interests and preferences.
- Supported Employment Group is not appropriate for individuals who demonstrate the capacity, ability and interest to work independently.
- An individual's autonomy and independence to perform employment with the least amount of restrictions must be supported through the person centered planning process.



Supported Employment (Individual) can be authorized, without a referral to VR, in those instances when:

- Individuals who in the delivery of waiver funded preparatory, planning and habilitative employment services (i.e. Career Planning or Prevocational Services) become employed.
- An individual has previously been determined ineligible for VR services or closed unsuccessfully from VR as “disability too severe”.
- An individual has previously accessed VR and their services were discontinued as VR established thresholds of support and/or outcomes were accomplished.

Supported Employment (Group) can be authorized without a referral to VR as VR does *not* provide this service.

The purposeful braiding of supports and services with VR to enhance the employment outcomes of individuals with DD is allowable under Code of Federal Regulations (CFR) for 1915(c) HCBS waivers as long as documentation supports that it is neither duplicative nor supplanting. Therefore, individuals can receive concurrent services from VR and 1915(c) funded services as long as documentation reflects VR supports and services are *not* otherwise available and/or exhausted.

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

Supported Employment may include assistance with reporting and managing earnings with Social Security and Medicaid.

However, Personal Assistance Service may not be used in lieu of Supported Employment services as defined above. PA services may be a component of Supported employment as necessary for the individual to participate in the service but may not comprise the entirety of the service.

- Transportation costs are not included in the supported employment rate, but transportation is available as a separate service if necessary and able to be coordinated through the person centered planning team.

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

Individuals who receive Supported Employment may also receive other day services. An individual’s support plan may include two or more types of non-residential services. Supported Employment has implementation elements which do *not* require an individual be present. As such, billing could occur during shared units of time with appropriate documentation.



FFP is *not* claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

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

Outcomes expected for this service are as follows:

1. Monthly progress report describing the results of the professional observation and assessment of the individual and their current and needed paid/unpaid supports to sustain employment. The progress report includes:

Summary of implementation strategies to maximize employment, independence, natural supports, job performance and minimize reliance on Medicaid waiver services to include addressing any identified potential risk associated with reduction of paid supports2. Training delivered to the individual to implement the strategies with fidelity and collect data to determine effectiveness of the strategies that will assist the individual with independence and reduction of paid supports.

Provider Requirements

This service can be provided by an employment services provider agency. The agency *must* be certified by DMH or accredited by CARF, CQL or Joint Commission to provide Supported Employment services. The agency *must* have a DMH contract and comply with training requirements outlined within the contract.

Staff Requirements

Staff delivering Supported Employment services *must* complete the following training requirements as outlined in contract:

- Fourteen (14) hours of Division of DD approved training, as outlined in contract, plus an additional six (6) hours of supervised practical mentoring/job coaching related to APSE Supported Employment Service competencies within the first twelve (12) months of hire. Annually thereafter, employees *must* complete four (4) additional hours of Division of DD approved training as outlined in the contract. Any staff member who has the following credentials are deemed as meeting all training requirements:
- CESP by passing the national CESP examination from the ESPCC or,
- National Certificate of Achievement in Employment Services from the Association of Community Rehabilitation Educators (ACRE).
- Direct Support Professional-Specialist-Employment Support credentialing issued by the NADSP.

Billing Information: Supported Employment

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Supported Employment, Individual	H2023	15 minutes	48 units per day
Supported Employment, Group	H2023 HQ	15 minutes	32 units per day



Supported Employment Service Documentation

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.

Supported Employment (Individual) has implementation elements which do *not* require an individual be present. Duplicative billing applies only to those services where an individual is concurrently receiving "in-person" services during the same unit of time. As such, billing could occur during shared units of time with appropriate documentation.

Providers of all these services *must* maintain an individualized plan and detailed record of monthly activities by unit of service. The provider is required to follow procedures set forth under The Code of State Regulations 13 CSR 70-3.030, which defines adequate documentation.

ISP's will include outcomes/goals, with criteria, and will be supported by data to demonstrate progress and implementation strategies that optimize autonomy and independence.

Providers *must* maintain service documentation described in Section C of the DD Waiver Manual, including detailed progress notes per date of service and monthly progress notes associated with objectives.

Temporary Residential Service

Available in PfH Waiver only

Service Description

Temporary Residential Service is care provided in the individual's place of residence, the community or outside the home in a licensed, accredited or certified waiver residential facility, ICF/ID or State Habilitation Center, stand-alone facility or Shared Living Host Home Relief/Relief Home by trained and qualified personnel for a period of no more than 60 days annually, unless a written exception is granted from the Regional Office Director. 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.

This service is *not* delivered in lieu of day care for children nor does it take the place of day services programming for adults. A unit of service is 15 minutes, when provided in increments less than 24 hours, or one day (24 hours).

Temporary Residential Service is provided to individuals unable to care for themselves, on a short-term basis. This service is also furnished because of the absence or need for relief of those persons who normally care for the participant. It is a residential support of providing temporary care, assistance and supervision directly to eligible persons 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.

Service Limitations



Temporary Residential service is limited to no more than 60 days annually, unless a written exception is granted from the regional office director. 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. The 60 days may be consecutive, unless the service is provided in an ICF/ID or State Habilitation Center. Temporary Residential Service provided in an ICF/ID or State Habilitation Center cannot exceed 30 days. The total limit of out of home respite is six (6) months. Any settings where individuals will be served for over 60 days must comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5). Temporary Residential Services are temporary and require a hard limit to the exception amount. This will not affect section 9817 of ARP.

A host home provider shall *not* provide Temporary Residential service if there is an individual currently residing in the home and receiving host home services. A host home provider may provide Temporary Residential service if there is not currently an individual residing in the home and receiving host home services.

Provider Requirements

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

- A valid DMH Group Home 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.

A Shared Living Host Home /Relief Home shall be certified according to 9 CSR 45-5.010-060; or accredited by CARF, CQL or Joint Commission.

A Stand-alone Respite Facility shall be certified according to 9 CSR 45-5.010-060; or accredited by CARF, CQL or Joint Commission.

Staff Requirements

All direct-care staff *must* be 18 years of age and have a HS 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 (1) 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 (5) 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 (5) 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 (1) month of the implementation date of the current plan, or within one (1) 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 (3) months of employment).

Billing Information: Temporary Residential

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Temporary Residential, Daily	H0045	Day	1 unit per day
Temporary Residential, ¼ hour	H0045	15 minutes	1 unit per day

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 support plan. A Transportation Trip is defined from pick up point to destination as specified in the ISP.

Regional offices *must* provide the transportation provider with information about any special needs of participants authorized for transportation services. 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 trip or one month.

Service Limitations

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 Non-Emergency Medical Transportation (NEMT) is limited to medical services covered in the state plan. State plan transportation does not cover transporting persons to waiver services.

Provider Requirements

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



Billing Information: Transportation

Waiver Service	Code(s)	Service Unit	Maximum Units of Service
Transportation	A0120	Month	1 unit per month
Ambulatory Zone 1 (0-10 miles)	A0110	Per Trip	2 units/day
w/Non-Ambulatory Modifications Zone 1 (0-10 Miles)	A0110 HE	Per Trip	2 units/day
Ambulatory Zone 2 (10+ to 20 Miles)	T2002	Per Trip	2 units/day
w/Non-Ambulatory Modifications Zone 2 (10+ to 20 Miles)	T2002 HE	Per Trip	2 units/day
Ambulatory Zone 3 (20+ Miles)	T2003	Per Trip	2 units/day
w/Non-Ambulatory Modifications Zone 3 (20+ Miles)	T2003 HE	Per Trip	2 units/day

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: Telehealth Services

The Division of DD established Telehealth Guidelines for OT, PT, ST and certain ABA waiver services. The following waiver services may be delivered to a participant using telehealth. Counseling was removed from the Comprehensive and Community Support waivers with dates of service on or after March 1, 2021.

Telehealth services *must not* be provided concurrently with other waiver services. Service definitions and staff qualifications did *not* change as defined in the Medicaid waiver applications.

OTs and PTs can conduct evaluations for home modifications via telehealth. The EAA procedure code S5165 with “TC” modifier (CIMOR use only) is used for these evaluations only.

Waiver Service	Code(s)
Behavior Identification Assessment	97151 HO



Behavior Identification Supporting Assessment-Observational	97152 HO, HN, HM
Adaptive Behavior Treatment with Protocol Modification	97155 HO & HN
Family Adaptive Behavior Treatment Guidance	97156 HO & HN
Group Adaptive Behavior Treatment with Protocol Modification (Previously Behavior Treatment Social Skills Group)	97158 HO & HN
Counseling (Counseling was removed from the Comprehensive and Community Support waivers with dates of service on or after March 1, 2021.)	H0004 TG
Environmental Accessibility Adaptations Consultation Only	S5165 TC
Occupational Therapy	97535—OT 97535—OT, COTA 97535—OT, Consultation
Physical Therapy	97110—PT 97110—PT, Consultation
Speech Therapy	92507—ST 92507—ST, Consultation

Provider Requirements

Providers of services via telehealth *must* have established policies and procedures that will address:

- A. Express consent obtained for telehealth service delivery from participants served and their guardian.
- B. Process for trouble-shooting and repairing any device or internet problems experienced by the participant during the delivery of the service. Service delivery provider secures appropriate special equipment or software and determines there is access to internet with sufficient bandwidth to support audio/video conferencing both at the site of the participant served and the provider.
- C. Process to ensure privacy during the delivery of service and of any records maintained if recording of session is possible, including antivirus software with HIPAA safeguards and secure audio/video platforms.
- D. Process for evaluating the benefits of telehealth as a service modality for each participant.

Service Limitations for Applied Behavior Analysis Services

All of the following limits apply to the participant's plan year. All ABA telehealth services may only be delivered in real time.

Behavior Identification Assessment—Interview and debriefing/review of assessment results.

Behavior Identification Supporting Assessment-Observational —At least 25% of total authorized units *must* be done face to face.



Adaptive Behavior Treatment with Protocol Modification—No more than 75% of observation and supervision of a technician’s services under Adaptive Behavior Treatment with Protocol Modification by technician, no more than 50% of QHCP direct service may be done through telehealth. Review of recordings of the services by a technician or of the behavior of the participant will *not* be considered a billable telehealth service.

Family Adaptive Behavior Treatment Guidance—No more than 75% of total authorized service units may be done through telehealth.

Group Adaptive Behavior Treatment with Protocol Modification (Previously Behavior Treatment Social Skills Group)—No more than 75% of total authorized service units may be done through telehealth.

If the delivery of the service would otherwise occur by the QHCP demonstrating or implementing a strategy directly, then a competency trained on-sight implementer *must* be present for the remote therapist to work through. The QHCP *must* include in the plan for services the local assistance that will be accessed if emergencies occur during the delivery of the ABA services via telehealth. The local assistance agencies or individuals *must* have given prior consent to serve as the emergency assistance, *must* have been competency trained in the plan and *must* be readily available any time this assistance might be required during the delivery of the ABA services.

The functional behavioral assessment (which is a combination of service codes 97151, 97152, and 0362T) *must* include specific assessment of the benefits and risks of service through telehealth. If telehealth is chosen as a part of the service package, the choice of telehealth modality should be made based on needs of the participant served, *not* the ease of the service provider. This need of the participant *must* be included in the documentation of this evaluation and should be part of the participant’s records when chosen as part of the service plan.

The Division of DD Area Behavior Analysts will monitor for participants approaching telehealth limits on ABA services by participant plan year. Participants who have exceeded their telehealth limits will be identified for provider recoupments.

Place of Service Code

The “02” Place of Service code has been added for telehealth. Providers *must* indicate telehealth as the place of service when submitting telehealth claims.

Documentation Requirements

Telehealth providers are required to keep a complete medical record of a telehealth service provided to a participant and follow applicable state and federal statutes and regulations for medical record keeping and confidentiality in accordance with 13 CSR 70-3.020 and 13 CSR 70-3.030 as described in the DD Waivers Manual. This includes detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP and the individual BSP. Written data shall be submitted to DMH staff as requested.



Section H: 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)**
- **Service Plan**
- **Qualified Providers**
- **Health and Welfare**
- **Administrative Authority**
- **Financial Accountability**

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 Centers for Medicare & Medicaid Services (CMS) required assurances 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

(Quality Improvement: Appendix B of waiver application)

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

- An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
- The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.

Service Plan

(Quality Improvement: Appendix D of waiver application)

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

- Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.
- Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
- Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.



- Participants are afforded choice between/among waiver services and providers.

Qualified Providers

(Quality Providers: Appendix C of waiver application)

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

- The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
- The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
- The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Health and Welfare

(Quality Improvement: Appendix G of waiver application)

Assurance: The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

- The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.
- The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.
- State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.
- The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Administrative Authority

(Quality Improvement: Appendix A of waiver application)

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

Financial Accountability

Assurance: The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.

- The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
- The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.