13.18 RESIDENTIAL HABILITATION (Comprehensive Waiver Only)

Residential habilitation services are only available to participants in the Comprehensive Waiver. Residential habilitation services provide care, skills training in activities of daily living, home management and community integration, and supervision (protective oversight). Residential habilitation can be offered in the following types of licensed, certified or accredited Community Residential Facilities (CRF) for individuals with MRDD: group homes, residential centers and semi-independent living situations**.**

13.18.A INCLUDED SERVICES AND SUPPLIES

The following services and supplies are included in the rate:

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

13.18.B RESIDENTIAL HABILITATION PROVIDER REQUIREMENTS

Residential habilitation service providers *must* have a DMH Home and Community Based Medicaid Waiver contract for the provision of residential habilitation services and one of the following**:**

- a valid DMH community residential facility license under 9 CSR 40-1, 2, 4, 5 or semi-independent living arrangement license under 9 CSR 40-1, 2, 4, 7 or Certification by the DMH under 9 CSR 45-5.010;
- accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF), in the area of Community Living Programs; or
- the Council on Quality & Leadership for Persons with Developmental Disabilities (The Council).

13.18.C RESIDENTIAL HABILITATION STAFF REQUIREMENTS

All direct-care staff *must*:

- Must be 18 years of age

And have the following

- a high school diploma or its equivalent*;
- current certification in a competency based CPR/First Aid Course;
- training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care;

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- training in the implementation of *(each consumer's)* person centered plan (within one month of employment) *(effective 9/1/07)* and training in a positive behavior support curriculum approved by the Division of MRDD (within 3 months of employment);
- Additionally, staff administering medication supervising self-administration of meds must have successfully meet the requirements of 9CSR 45-3.070.

*Exemptions to H.S. diploma/GED requirement

1. Staff without diplomas or GEDs employed by the same provider prior to 7-1-96 are "grandfathered."
2. Staff without diplomas or GEDs may be employed for up to one year, while the person works to attain the requirement. The provider *must* document the staff's enrollment in school or GED courses
3. After 7-1-96, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional center. The provider is responsible for maintaining documentation of the five years of experience and of regional center agreement in the employee's file.

13.18.D RESIDENTIAL LEVELS OF CARE FOR SERVICES PROVIDED IN GROUP AND RESIDENTIAL FACILITIES

Residential habilitation providers who provide services in group homes or residential centers *shall* maintain appropriate levels of staff according to the following Division of MRDD residential levels-of-care model**:**

13.18.D(1) 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
- QMRP—minimum of 1.66 hours per week per 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.

13.18.D(2) 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
- QMRP—minimum of 2.5 hours per week per 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.

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13.18.D(3) 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
- QMRP—minimum of 2.5 hours per week per 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.

13.18.E RESIDENTIAL LEVELS OF CARE FOR SERVICES PROVIDED IN SEMI-INDEPENDENT LIVING (SIL) ARRANGEMENTS

Residential habilitation providers who provide services in semi-independent living (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 center. The provider shall maintain a copy of the approved staffing plan**.**

13.18.F RESIDENTIAL HABILITATION UNIT OF SERVICE

- Medicaid procedure code: T2016HIHQ
- Unit of service: one day (24 hours)
- Maximum units: 1/day

13.18.G RESIDENTIAL HABILITATION SERVICE DOCUMENTATION

Implementation of services must be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive residential habilitation. Residential Habilitation providers are required to document the provision of MRDD Waiver services as referenced in Section 13.10.A. of this manual.

13.19 INDIVIDUALIZED SUPPORTED LIVING (Comprehensive Waiver Only)

Individualized Supported Living (ISL) Services are only available to persons who participate in the Comprehensive Waiver. This is a non-facility based form of residential habilitation which provides support and training services to an individual in the individual's own residence. Individualized supported living (ISL) allows individuals with even the most severe disabilities the opportunity for community living.

Individuals may live alone or with their families or may share living arrangements with others. When living arrangements are shared, no more than three individuals with disabilities may reside together and qualify for ISL services.

Because it is neither group nor facility based, the ISL service model provides consumers maximum involvement in developing and carrying out their own service plans. Also,

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training and support are provided on-site in the home or in the community, thereby allowing functional skill development to occur in the real life settings where the skills are used. The nature, amount and cost of services and supports needed to carry out each plan depend on that consumer's needs, abilities, resources and informal support systems. Therefore, ISL services and supports are individually planned and budgeted for each person served.

Emphasis is placed on individuals choosing where they reside, with whom they reside and the type of community activities in which they wish to be involved. Except when the individuals served are children, the residence must be owned or leased by at least one of the residents or by the family or guardian of one of the residents. No payment is made for services provided, directly or indirectly, by members of the individual's immediate family.

13.19.A LEAD AGENCY

The concept of Individualized Supported Living requires a lead agency. The lead agency provides day to day case coordination and is also expected to provide a safety net for the individual, including 24-hour response capability and a regular point of contact for each individual served. The responsibility for case coordination generally is borne by the provider of direct service, but may reside with family members, regional center staff or others. The consumer's plan formally specifies any alternative arrangements and only the provider of direct service may be paid a fee for case coordination.

13.19.B ISL BUDGET

The ISL budget for each consumer is flexible, allowing payment for direct care and professional staff hours to reflect the service and support actually needed by the individual. The budget may also include a case coordination fee and agency administrative fee. The cost for any direct care and professional staff, case coordination, agency administrative fee, and other allowable costs are calculated to arrive at a total monthly service cost. A per diem rate is derived from the total monthly service cost. The per diem rate shall not exceed the statewide maximum allowable payment.

The provider bills for each day in the month for which services were authorized and delivered. The provider may not bill for any day the individual was not present or did not receive direct service. When a provider delivers services on fewer days in the month than were authorized, the provider's allowable monthly costs will be redistributed across the days the individual was present and did receive services to arrive at an adjusted per diem rate. However, the daily per diem rate that results from the redistribution cannot exceed the current Medicaid maximum allowable daily rate established by the Division of MRDD. If a provider does not deliver direct care services on any day within a month, the provider is not entitled to payment for any portion of the monthly authorized amount. The following service and staff costs may be included in the budget**:**

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13.19.B(1) Case Coordination

As described above, if the ISL provider of direct service is responsible for coordination, a standard fee per month is included in the budget. The standard fee may be reduced by the regional center, if an alternate is designated to provide the coordination. The function of case coordination may be provided by the provider of direct service (lead agency), by the regional center, or by someone else such as a member of the individual's family. Only the provider of direct service, however, may be paid the additional flat fee for case coordination. Case coordination is not reimbursable as a separate ISL service. It is paid as a component of the calculated per diem rate when direct care services are provided. If the provider does not deliver direct care services on any day within a month, the provider shall not be reimbursed for any portion of the case coordination fee**.**

13.19.B(2) Community Specialist

This is the primary manager of the ISL program within the provider agency. The position requires a QMRP with a Masters Degree, or with a Bachelors Degree and three years experience in working with persons with developmental disabilities. This position provides planning, training, supervision and quality assurance.

13.19.B(3) Community Integration Skills Trainer (CIST)

The Community Integration Skills Trainer (CIST) supervises and trains direct support staff, is directly involved in care planning, designs training programs, monitors program implementation and writes monthly reviews. The CIST also identifies community resources and facilitates opportunities for natural supports and community integration. In small agencies or in situations with individuals requiring less intensive intervention, the QMRP qualified CIST may serve as the primary manager, thereby removing the need for a Community Specialist. The CIST position requires a QMRP with at least a Bachelors Degree in a related discipline and one year of experience in the field of MRDD or, with written approval of the regional center director, a candidate may substitute experience working with persons with developmental disabilities year for year for the educational requirement.

13.19.B(4) Direct Support Staff

These staff provide support and training, and where needed, oversight. Examples of duties are: assistance with routine chores, transportation, and accompaniment to activities or into the community, meal preparation and assistance with activities of daily living.

All direct-care staff *must*:

- Must be 18 years of age

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And have the following

- a high school diploma or its equivalent*;
- current certification in a competency based CPR/First Aid Course;
- training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care;
- training in the implementation of *(each consumer's)* person centered plan (within one month of employment) *(effective 9/1/07)* and training in a positive behavior support curriculum approved by the Division of MRDD (within 3 months of employment);
- Additionally, staff administering medication supervising self-administration of meds must have successfully met the requirements of 9CSR 45-3.070.

*Exemptions to H.S. diploma/GED requirement

4. Staff without diplomas or GEDs employed by the same provider prior to 7-1-96 are "grandfathered."
5. Staff without diplomas or GEDs may be employed for up to one year, while the person works to attain the requirement. The provider *must* document the staff's enrollment in school or GED courses
6. After 7-1-96, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional center. The provider is responsible for maintaining documentation of the five years of experience and of regional center agreement in the employee's file.

13.19.B(5) Administrative Fee

An Administrative charge based on the direct service costs. The agency's usual and customary administrative rate is applied to the total direct service costs to arrive at the administrative fee. The monthly fee may not exceed the limit or cap set by the Division of MRDD. The administrative fee is not reimbursable as a separate ISL service. It is paid as a component of the calculated per diem rate when direct care services are provided. If the provider does not deliver direct care services on any day within a month, the provider shall not be reimbursed for any portion of the administrative fee.

13.19.B(6) Included Costs

Costs associated with individualized supported living may be included in the rate as follows:

Note: Budgeting additional hours or costs for "relief staff" are not allowed. All hours expected to be delivered are already budgeted and payment for time not worked is included in the rate for each hour, so budgeting additional hours or costs for "relief staff" duplicates hours and costs already included.

An hourly rate for each of the staff positions listed above: Community Specialist, Community Integration Skills Trainer and Direct Support Staff. Payment is for an hour of delivered service. The hourly rate for each position is negotiated and set by contract, up to a statewide maximum. The maximum hourly rate includes 33 percent for associated fringe. Associated fringe includes any coverage by the provider of:

mandatory taxes (social security, workman's compensation, long term disability, unemployment insurance);

retirement pension;

insurance (life, health, liability, other); and

payment for time not worked (vacation, sick leave, holidays).

Mileage for staff who drive their own vehicles to the consumer's home or who use their own vehicles to transport consumers, except that travel between the worker's home and the consumer's residence shall be treated as travel to and from a base of work and is not reflected on the ISL budget.

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 caretaker may be added to the residential habilitation costs on the right side of the budget. This payment requires that the lead agency and/or the live-in caretaker contribute the same amount to the individual being served for payment of rent or utilities or for purchase of food. This payment is not available if the consumer resides in the home of a caregiver or in a home owned or leased by the lead agency.

Other costs: As needed, other costs such as locating alternative housing, specialized training, and supplies required for that individual's support and habilitation services, may be included in the individual's budget.

Note: Transportation costs may be paid to the ISL provider through a separate service code. See Section 19.1 under transportation. This code can be used to reimburse a lead agency's costs for transporting an individual, monthly, but it does not cover staff travel costs. Room and board costs are calculated and paid separately.

13.19.C STAFFING PLAN

A complete staffing plan must accompany each ISL budget submitted to the regional center for approval. The plan must correspond to the total staff hours included as costs on the ISL budget and must show the hours staff is present during a 24-hour and seven day-a-week period. Total staff hours cannot exceed 24-hours in a day. When overnight staff hours are included on the budget, it is assumed the staff is awake, unless the plan states otherwise.

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13.19.D CHANGING THE BUDGET

The ISL budget can be amended by mutual agreement between the lead agency and the regional center. It must be amended within the month of service and before any billing has been sent.

13.19.E REPORTING REDUCTIONS IN SERVICES

In accordance with the lead agency's DMH 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 regional center within the month of service or the following month and the regional center either adjusts the monthly budget amount prospectively or approves the variance in writing. Variances of five percent or more require approval by the Deputy Director for the district or the Director's designee.

13.19.F INDIVIDUALIZED SUPPORTED LIVING PROVIDER REQUIREMENTS

An Individualized Supported Living Provider must have a DMH Home and Community Based Medicaid Waiver contract for the provision of ISL services and one of the following:

- accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) in the area of Integrated Living Programs;
- accreditation by the Council for Quality & Leadership for Persons with Developmental Disabilities (The Council);
- Certification by DMH under 9 CSR, 45-5.010; or
- Licensure by DMH as a Family Living Arrangement (FLA) under 9 CSR 40-1, 2, 4, 6.*

*A FLA is defined as a living arrangement where three or less individuals are living in a home owned or leased as the permanent residence of the provider, where the individuals are integrated into the family unit. All new living arrangements established after March 31, 2005, meeting this definition must be licensed as a FLA.

13.19.G INDIVIDUALIZED SUPPORTED LIVING UNIT OF SERVICE

- Medicaid procedure code: Comprehensive Waiver: T2016HI
- A unit of service: one day (24 hours)
- Maximum units: one/day.

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13.19.H INDIVIDUALIZED SUPPORTED LIVING SERVICE DOCUMENTATION

Implementation of services must be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive individualized supported living. Individualized Supported Living providers are required to document the provision of MRDD Waiver services as referenced in Section 13.10.A of this manual.

13.20 DAY HABILITATION SERVICES (Comprehensive, Community Support and Lopez)

Day habilitation is provided to enable individuals to achieve optimal physical, emotional, sensory, and intellectual functioning. The purpose of the service is to enable and increase independent functioning, physical health and development, language and communication development, cognitive training, socialization, community integration, domestic and economic management, functional skills development (ADLs, IADLs), behavior management, responsibility and self-direction. Services may include training families in treatment, intervention and support methodologies and in the care and use of equipment. Day habilitation services may also include coordination and intervention with the individual, family, professionals and others involved with the individual, as needed to implement the person centered plan and as directed by the planning team with the approval of the regional center.

Day habilitation services may be provided to individuals or in small groups and may be provided either on-site, at the day program or off-site, in the individual's own home or community. On-site group and off-site individual settings are normal; the other two variations are for specific and unusual situations. Regional Centers may contract for any or all of the four modes as needed.

Off-site training and support are intended to maximize self-determination and participation in the community; therefore, this service must employ strategies which promote inclusion and self-determination, maximize the individual's participation in the experience and address a specific functional purpose. The outcomes expected of off-site services include opportunities for repeated exposure to community life; development of social contacts, friendships and natural support systems; increased functional independence or interdependence in areas related to community inclusion; and reduction of specialized supports due to increased independence or linkage to a system of natural supports in the community. The planning team determines the content of the service and the site(s) and mode(s) of learning which best meets the needs of each individual. The planning team also ensures that day habilitation services are coordinated with any therapies the individual requires and that the day habilitation services do not duplicate any other services authorized for the individual.

For the Sarah Lopez Waiver,. These services may not duplicate or replace special education and related services (as defined in Section 4(a)(4) of the 1975 Amendments to the Education of the Handicapped Act (20 USC 1401 (16), (17)) which otherwise are

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available to the child through a state or local education agency. Day habilitation may not include vocational and pre-vocational services, nor may individuals earn income as part of participation in this service

13.20.A DAY HABILITATION STAFF REQUIREMENTS

All direct-care staff *must*:

- Must be 18 years of age

And have the following

- a high school diploma or its equivalent*;
- current certification in a competency based CPR/First Aid Course;
- training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care;
- training in the implementation of *(each consumer's)* person centered plan (within one month of employment) *(effective 9/1/07)* and training in a positive behavior support curriculum approved by the Division of MRDD (within 3 months of employment);
- Additionally, staff administering medication supervising self-administration of meds must have successfully meet the requirements of 9CSR 45-3.070.
- One year experience working with people with developmental disabilities or in lieu of experience, must successfully complete training in the Missouri Quality Outcomes approved by the DMRDD regional center.

*Exemptions to H.S. diploma/GED requirement

7. Staff without diplomas or GEDs employed by the same provider prior to 7-1-96 are "grandfathered."
8. Staff without diplomas or GEDs may be employed for up to one year, while the person works to attain the requirement. The provider *must* document the staff's enrollment in school or GED courses
9. After 7-1-96, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional center. The provider is responsible for maintaining documentation of the five years of experience and of regional center agreement in the employee's file.

13.20.B DAY HABILITATION SUPERVISION

Day habilitation services must be supervised by a qualified mental retardation professional (QMRP) as defined in Section 13.17 of this manual.

13.20.C DAY HABILITATION PROVIDER REQUIREMENTS

Day habilitation providers must have a DMH Home and Community Based Medicaid Waiver contract for provision of day habilitation services and one of the following:

- A valid DMH day habilitation license under 9 CSR 40-1, 2, 9 or Certification by the DMH under 9 CSR 45-5.010;
- Accreditation by the Commission on Accreditation of Rehabilitation Facilities in the area of Personal, Social and Community Services; or

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- Accreditation by The Council for Quality & Leadership for Persons with Developmental Disabilities (The Council).

13.20.E DAY HABILITATION UNITS OF SERVICE

13.20.E(1) On-Site Day Habilitation-Group

Services are delivered at the Day Habilitation Center, but may include incidental off site activities. Group size may vary between 1:2 and 1:6.

- Medicaid procedure code:
- Comprehensive Waiver: T2021HIHQ
- Lopez Waiver: T2021HIHQ
- Community Support Waiver: T2021U1HQ
- Unit of Service: 15 minutes
- Maximum units: 32/day

13.20.E(2) On-Site Habilitation—Individual

Services are delivered at the Day Habilitation Center with a 1:1 staff to participant ratio. This service is available when an individual needs the higher staffing ratio to learn a particular skill or during a transition period or when the individual's behavior and/or health require it.

- Medicaid procedure code:
- Comprehensive Waiver: T2021HI
- Lopez Waiver: T2021HI
- Community Support Waiver: T2021U1
- Unit of Service: 15 minutes
- Maximum units: 32/day

13.20.E(3) Off-Site Day Habilitation—Group

Services are delivered in the community, in natural and typical settings such as a store, post office, bank, governmental office, church, park or other recreation site. Group size may not exceed 1:4. This service may not be provided in a group home to residents of that home. Transportation costs needed to provide this service are included in the fee for service.

- Medicaid procedure code:
- Comprehensive Waiver: T2021HIHQSE
- Lopez Waiver: T2021HIHQSE
- Community Support Waiver: T2021U1HQSE
- Unit of service: 15 minutes
- Maximum units: 32/day

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13.20.E(4) Off-Site Day Habilitation—Individual

Services are delivered in the community or in the person's own home with a 1:1 staff to participant ratio. Transportation costs needed to provide this service are included in the fee for service.

- Medicaid procedure code:
- Comprehensive Waiver: T2021HISE
- Lopez Waiver: T2021HISE
- Community Support Waiver: T2021U1SE
- Unit of Service: 15 minutes
- Maximum units: 48/day

13.20.F. DAY HABILITATION SERVICE DOCUMENTATION

The provider of any Day Habilitation service is required to follow procedures set forth under "Documentation" in Section 13.10.A. of this manual.

13.21 PHYSICAL THERAPY (Comprehensive and Community Support)

Physical therapy is a service designed to treat 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 affecting the acquisition of skills needed for adaptive functioning at the highest level of independence for that individual. This service may include clinical consultation to individuals, parents, primary caregivers or other programs. Physical therapy services may not be carried out by a paraprofessional. For children and youth under the age of 21, physical therapy services should be accessed through HCY.

13.21.A PHYSICAL THERAPY PROVIDER REQUIREMENTS

Physical therapy providers must have a DMH Home and Community Based Medicaid Waiver contract for the provision of physical therapy services and must be registered as a physical therapist with the Division of Professional Registration in the State of Missouri, RSMo, 1990, 334.530-334.625.

13.21.B PHYSICAL THERAPY UNIT OF SERVICE

- Medicaid procedure code:
- Comprehensive Waiver: 97110HI
- Community Support Waiver: 97110U1
- Unit of Service: 15 minutes
- Maximum units: eight/day

13.21.C PHYSICAL THERAPY SERVICE DOCUMENTATION

Physical Therapy providers must maintain service documentation as described in Section 13.10.A of this manual.

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13.22 OCCUPATIONAL THERAPY (Comprehensive and Community Support)

Occupational therapy requires prescription by a physician and evaluation by a certified occupational therapist (OT) or certified occupational therapeutic assistant (COTA) under the supervision of an OT. The service includes evaluation, plan development, direct therapy, consultation and training of caretakers and others who work with the individual. It may also include therapeutic activities carried out by others under the direction of an OT or COTA . Examples are using adaptive equipment, proper positioning and therapeutic exercises in a variety of settings. This service should be accessed through HCY for children and youth under the age of 21.

13.22.A OCCUPATIONAL THERAPY PROVIDER REQUIREMENTS

Occupational therapy providers must have a DMH Home and Community Based Medicaid Waiver contract for provision of occupational therapy. To obtain this contract, providers must either be certified as an occupational therapist by the American Occupational Therapy Association or registered as a Certified Occupational Therapeutic Assistant (COTA) under RSMo 1990, 334.735-334.746. Requirements that must be met by COTAs in Missouri are:

- Attainment of a two-year associate degree from an accredited college;
- Successful completion of a state exam; and
- Registration with the State Division of Professional Registration.

In addition, COTAs must receive supervision from a professional OT that is on a periodic, routine and regular basis.

13.22.B OCCUPATIONAL THERAPY UNIT OF SERVICE

- Medicaid procedure code:
- Comprehensive Waiver: 97535HI
- Community Support Waiver: 97535U1
- Unit of Service: 15 minutes
- Maximum units: eight/day

13.22.C OCCUPATIONAL THERAPY SERVICE DOCUMENTATION

Occupational Therapy providers must maintain service documentation as described in Section 13.10.A of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the consumer's person centered plan, service plan or plan of care. Written data shall be submitted to DMH authorizing staff as required.

13.23 SPEECH THERAPY (Comprehensive and Community Support)

Speech therapy is provided for individuals who have speech, language or hearing problems. The individual's need for therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. Services must be required in the plan of care and prescribed by a physician. Speech therapy provides treatment for these and other disorders: delayed speech, stuttering,

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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 service providers. This service may not be provided by a paraprofessional. For children and youth under the age of 21, speech therapy should be accessed through HCY.

13.23.A SPEECH THERAPY PROVIDER REQUIREMENTS

Speech and language therapy providers must have a DMH Home and Community Based Medicaid Waiver contract for provision of speech and language therapy and must be licensed as a speech pathologist with Division of Professional Registration in the State of Missouri. Provisionally licensed speech therapists supervised by a licensed speech therapist may also provide services if employed by an enrolled licensed speech therapy provider.

13.23.B SPEECH THERAPY UNIT OF SERVICE

- Medicaid procedure code:
- Comprehensive Waiver: 92507HI
- Community Support Waiver: 92507U1
- Unit of Service: 15 minutes
- Maximum units: eight/day

13.23.C SPEECH THERAPY SERVICE DOCUMENTATION

Speech Therapy providers must maintain service documentation as described in Section 13.10.A of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the consumer's person centered plan, service plan or plan of care; Written data shall be submitted to DMH authorizing staff as required.

13.24 BEHAVIORAL THERAPY (Comprehensive, Community Support, and Lopez)

This service provides systematic behavior analysis and assessment, behavior management plan development, consultation, environmental manipulation and training to and for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation, self direction or community integration and/or are threatening to require movement to a more restrictive placement. This service may also include consultation provided to families, other caretakers and habilitation service providers. The unit of service is one-fourth hour.

All behavior management programs must meet and comply with the current version of "Guidelines and Procedures for the use of Behavior Management Techniques", State of Missouri, Department of Mental Health, Division of Mental Retardation and Developmental Disabilities.

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13.24.A BEHAVIORAL THERAPY PROVIDER REQUIREMENTS

Behavior therapists must have a DMH Home and Community Based Medicaid Waiver contract for provision of behavior therapy services and must:

- Be a Qualified Mental Retardation Professional (QMRP), as defined in Section 13.17 of this manual. The DMRDD regional center and the DMH contracts management unit verify the applicant's status as a QMRP as a condition of finalizing the above-mentioned contract.
- Be an agency employing a QMRP-Qualified Behavior Therapist as defined in Section 13.17 of this manual.

13.24.B BEHAVIORAL THERAPY UNIT OF SERVICE

- Medicaid procedure code:
- Comprehensive Waiver: H0004HI
- Lopez Waiver: H0004HI
- Community Support Waiver: H0004U1
- Unit of Service: 15 minutes
- Maximum units: 32/day

13.24.C BEHAVIORAL THERAPY SERVICE DOCUMENTATION

Behavior Therapy providers must maintain service documentation as described in Section 13.10.A of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the consumer's person centered plan, service plan or plan of care. Written data shall be submitted to DMH authorizing staff as required.

13.25 IN-HOME RESPITE CARE (Comprehensive, Community Support and Lopez)

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

A unit of service is 15 minutes or one day. The only limitation on total hours provided is that they be necessary to avoid institutionalization and remain within the overall cost effectiveness of each individual's plan. The service is provided in the individual's place of residence, at a qualified day program site or elsewhere in the community. If the service includes overnight care, it must be provided in the individual's place of residence.

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13.25.A IN-HOME RESPITE PROVIDER REQUIREMENTS

In-home respite may be provided either by an individual provider or by an employee of an agency. The determination of which type of provider delivers the service is the choice of the individual and/or the individual's family or guardian, with the limitation that for an individual provider to be used, the individual consumer and/or family or guardian must be able and willing to supervise the provider and the planning team must certify that this supervision is sufficient to safeguard the individual consumer's health and safety.

13.25.A(1) Provider Supervision

Supervision is provided by a QMRP or by the consumer or the consumer's family or guardian. In cases, the frequency and scope of the supervision is specified in the plan of care

13.25.A(2) Relatives as Providers

(a) For the Sarah Lopez Waiver Only:

In-home respite services provided to a person by a member(s) of the person's immediate family (natural, half- or step-relationships with parent, child, sibling or spouse) may not be reimbursed under the wavier. Other persons related to the consumer may provide this service under the waiver if they meet the same age and training requirements as other providers. There must be a determination by the planning team, documented in the person's plan, that such an arrangement best meets the particular needs of the individual.

(b) For the Comprehensive and Community Support Waiver Only:

In-home respite services may not be provided by an individual's spouse or if the individual is a minor (under age 18) by a parent. In-Home Respite services may otherwise by provided to a person by a member (s) of his or her family when:

- The person is not opposed to the family member providing the service
- The service to be provided does not primarily benefit the family unit,
- The service is not a household task family members expect to share or do for one another when they live in the same household,
- Otherwise is above and beyond the typical activities family members provide for another adult family member without a disability.

Additionally, the following conditions, documented in the person's plan, must be met:

- The service would otherwise need to be provided by a qualified provider;
- A qualified provider who is not a family member is not available to provide the service or can only provide the service at an extraordinarily higher cost than the fee or charge negotiated with the qualified family member; and
- The planning team determines the family member providing the In-Home Respite service will best meet the individual's needs.

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Only the hours of service determined necessary through the assessment and person centered planning process may be authorized and the authorized hours of care may fluctuate based on the needs of the individual. Family members providing paid care shall not be guaranteed a set number of hours to ensure the family member a steady income.

Family members approved to provide In-Home Respite services may be employed by an agency or employed by the person/family using an approved fiscal intermediary. A family member approved to provide In-Home Respite services shall not also be the person's legal representative (guardian). If the person employs his/her own workers using an approved fiscal intermediary, the family member serving as a paid In-Home Respite assistant, shall not also be the employer of record. Family members may not be authorized and paid for overtime. The DMRDD may establish annually a maximum allowable rate to be paid to family members. Family members approved to provide In-Home Respite services shall meet the same age and training requirements as other providers. There must be a determination by the planning team, documented in the person's plan, that such an arrangement best meets the particular needs of the individual.

13.25.A(3) Individual Employed by Consumer or Family

An individual provider of in-home respite may, if the provider falls outside the federal definition of "domestic service worker," (and is, therefore, responsible for his or her own tax withholdings), enroll directly with the Medicaid Program or with an Organized Health Care Delivery System to provide this service.

Most respite workers, however, fall into the category of "domestic service worker," and someone needs to be that worker's employer. The state considers such individual providers the employee of the consumer or family for whom they work. But rather than holding the consumer or family responsible for withholding taxes and performing all other required employer functions, the state contracts with fiscal intermediaries to perform some or all of these functions on their behalf. The rate per unit of service that is billed to Medicaid may include the respite worker's wages, the employer's share of taxes, any worker benefits and the fiscal intermediary's administrative costs.

The employee of the consumer/family must be at least age 18, meet minimum training requirements, and have agreements with DMRDD and with the consumer/family.

To the extent they desire, the consumer and the consumer's family/guardian selects the respite worker, assists with training and maintains supervision. Training can be provided by the regional center or by a sponsoring agency or by the consumer, the consumer's family or guardian and covers:

The rights and responsibilities of the provider and the consumer, procedures for billing and payment, record keeping requirements and who to contact within the regional center;

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Information about the specific condition and needs of the person to be served and training in the care and assistance the respite worker needs to provide; and

- **Training or verification of training in CPR and first aid and, if needed, training in medication administration and/or behavioral intervention techniques approved by the regional centers**

The consumer, the consumer's family or guardian must approve the selection of the respite worker and a Client Choice of Provider Statement to this effect is maintained by the regional center. A checklist of the training provided is maintained with the statement. With the agreement of the consumer, the consumer's family or guardian, the regional center may exempt a prospective respite provider from those parts of the required minimum training when the provider is judged to possess adequate knowledge or experience or when the duties do not require those particular skills. This exemption must be specified on the checklist maintained with the Client Choice of Provider Statement.

13.25.A(4) Individual Employed by an Agency

An agency-based provider must be employed by one of the following:

- **A DMH-certified or CARF/The Council-accredited provider of Residential Habilitation or Individualized Supported Living Services;**
- **A DMH-certified or CARF/The Council-accredited provider of Day Habilitation Services;**
- **A Medicaid-enrolled provider of personal care, respite* or homemaker* services;**
- **A temporary employment agency whose employee is trained and supervised by the family or consumer in accordance with the requirements for an individual provider; or**
- **An agency which contracts with DMH to provide in-home respite and which submits a written proposal specifying its procedures for recruitment of staff, background checks, training and supervision.**

The agency-based provider of in-home respite care must be trained and supervised in accordance with the certification or program enrollment requirements that apply, but training must include at least the minimum specified above for the individual provider. In addition, the planning team may specify additional qualifications and training necessary to carry out the plan.

13.25.B IN-HOME RESPITE UNIT OF SERVICE

13.25.C(1) One Day

- **Medicaid procedure code:**
- **Comprehensive Waiver: S5151HI**
- **Comprehensive Waiver-Consumer-Directed S5151HIU2**
- **Lopez Waiver: S5151HI**

- **Community Support Waiver: S5151U1**
- **Community Support Waiver- Consumer-Directed S5151U1U2**
- **Unit of Service: one day**
- **Maximum units: one/day, no maximum per year as long as cost effectiveness is maintained.**

13.25.C(2) 15 Minutes—Individual

- **Medicaid procedure code:**
- **Comprehensive Waiver: S5150HI**
- **Comprehensive Waiver- Consumer-Directed S5150HIU2**
- **Lopez Waiver: S5150HI**
- **Community Support Waiver: S5150U1**
- **Community Support Waiver- Consumer-Directed S5150U1U2**
- **Unit of Service: 15 Minutes**
- **Maximum units: 40 units/day, no maximum per year as long as cost effectiveness is maintained.**

13.25.C(3) 15 Minutes—Group

- **Medicaid procedure code:**
- **Comprehensive Waiver: S5150HIHQ**
- **Lopez Waiver: S5150HIHQ**
- **Community Support Waiver: S5150U1HQ**
- **Unit of Service: 15 Minutes**
- **Maximum units: 40 units/day, no maximum per year as long as cost effectiveness is maintained.**

13.25.C IN-HOME RESPITE SERVICE DOCUMENTATION

Providers of respite care *must* maintain documentation as set forth in Section 13.10.A of this manual, including attendance records and progress notes. When the In-Home Respite provider employer of record is the consumer or the consumer's family, the consumer or family is responsible for ensuring adequate documentation in accordance with Section 13.10.A. is maintained. Written data shall be submitted to DMH authorizing staff as required.

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13.26 OUT OF HOME RESPITE CARE

Out of home respite care consists of temporary care provided outside the home in a licensed or accredited or certified Waiver Residential Care Facility (RCF), ICF-MR or State Habilitation Center for a period of no less than 24 hours by trained, qualified personnel, on an intermittent basis. The purpose of respite care is to provide temporary relief to the customary caregiver. As much as is practically possible, the individual's regular programs are maintained while in respite care. There is no annual limit to the days of out-of-home respite so long as the service is cost effective when combined with all other waiver and state plan community-based services provided to the individual.

13.26.A OUT OF HOME RESPITE PROVIDER REQUIREMENTS

Out of home respite care providers *must* have a DMH Home and Community Based Medicaid Waiver contract for the provision of respite care and one of the following:

- **A valid DMH community residential facility license under 9 CSR 40-1, 2, 4, 5 or certified by the DMH under 9 CSR 45-5.010;**
- **Accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF), in the area of Community Living Programs;**
- **The Council for Quality & Leadership for Persons with Developmental Disabilities (The Council); or**
- **Certified ICFs/MR and Division of MRDD Habilitation Centers may be enrolled to provide out of home respite care.**

All direct-care staff *must*:

- Must be 18 years of age

And have the following

- a high school diploma or its equivalent*;
- current certification in a competency based CPR/First Aid Course;
- training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care;
- training in the implementation of *(each consumer's)* person centered plan (within one month of employment) *(effective 9/1/07)* and training in a positive behavior support curriculum approved by the Division of MRDD (within 3 months of employment);
- Additionally, staff administering medication supervising self-administration of meds must have successfully meet the requirements of 9CSR 45-3.070.

*Exemptions to H.S. diploma/GED requirement

10. Staff without diplomas or GEDs employed by the same provider prior to 7-1-96 are "grandfathered."
11. Staff without diplomas or GEDs may be employed for up to one year, while the person works to attain the requirement. The provider *must* document the staff's enrollment in school or GED courses
12. After 7-1-96, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional center. The provider is responsible for maintaining documentation of the five years of experience and of regional center agreement in the employee's file.

13.26.B OUT OF HOME RESPITE UNIT OF SERVICE

- **Medicaid procedure code:**
- **Comprehensive Waiver: H0045HI**
- **Lopez Waiver: H0045HI**
- **Community Support Waiver: H0045U1**
- **Unit of Service: one day**
- **Maximum units: one/day, no maximum per year as long as cost effectiveness is maintained.**

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13.26.C OUT OF HOME RESPITE SERVICE DOCUMENTATION

Out of Home Respite Care providers *must* maintain service documentation as described in Section 13.10.A of this manual, including attendance records and progress notes. Written data shall be submitted to DMH authorizing staff as required.

13.27 TRANSPORTATION (Comprehensive, Community Support, and Lopez)

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

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

13.27.A TRANSPORTATION PROVIDER REQUIREMENTS

Providers *must* satisfy all State of Missouri licensure requirements and applicable State of Missouri statutes for both drivers and vehicles under RSMo, Chapter 302. Providers *must* have a DMH Home and Community Based Medicaid Waiver contract for the provision of transportation services.

13.27.B TRANSPORTATION UNIT OF SERVICE

- **Medicaid procedure code:**
- **Comprehensive Waiver: A0120HI**
- **Lopez Waiver: A0120HI**
- **Community Support Waiver: A0120U1**
- **Unit of Service: one month of transportation**
- **Maximum units: one/month.**

13.27.C TRANSPORTATION SERVICE DOCUMENTATION

Transportation providers shall follow procedures as described in "Documentation" Section 13.10.A of this manual as it applies to this service. To document service delivery, a transportation provider must maintain:

- **individual trip records for each individual transported;**
- **mileage or zone records of miles or zones provided; and**
- **accurate records of transportation costs.**

- **13.28 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (HOME MODIFICATION) (Comprehensive, Community Support and Lopez)**

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Environmental accessibility adaptations are those physical adaptations required by the individual's plan of care which are necessary to ensure the health, welfare and safety of the individual or which enable the individual to function with greater independence in the home and community and without which the individual requires institutionalization.

13.28.A COVERED ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

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 those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver participant, such as carpeting, roof repair, central air conditioning, home additions solely intended to increase living space square footage, etc.

(For Comprehensive and Community Support Waiver: Adaptations that add to the total square footage of the home are excluded from this benefit except where necessary to complete the adaptation. Adaptations may be approved for living arrangements (houses, apartments, etc.) where the participant lives, owned or leased by the participant, their family or legal guardian.)

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

All adaptations must be recommended by an appropriate therapist. Plans for installations should be coordinated with the therapist to ensure adaptations will meet the needs of the individual as per the recommendation. The therapist must oversee the purchase of equipment and actual construction to ensure it meets standards for accessibility.

13.28.B ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS PROVIDER REQUIREMENTS

The provider *must* have a current DMH Home and Community Based Medicaid Waiver contract specific to the provision of home modification and *must* meet all local building codes.

13.28.C ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS SERVICE LIMITATIONS

Environmentally accessible adaptation service is limited to $5,000 per year, per participant

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13.28.D ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS UNIT OF SERVICE

- **Medicaid procedure code:**
- **Comprehensive Waiver: S5165HI**
- **Lopez Waiver: S5165HI**
- **Community Support Waiver: S5165U1**
- **Unit of Service: one job**
- **Maximum expenditure: $5,000 of modifications per individual, per year.**

13.28.E ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS SERVICE DOCUMENTATION

Environmental Accessibility Adaptations providers shall maintain documentation as described in 13.10.A of this manual as it applies to this service. The MRDD Regional Center must be provided with an itemized invoice documenting the specific modifications that were provided prior to billing.

13.29 SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (ADAPTIVE EQUIPMENT) (Comprehensive, Community Support, and Lopez)

Specialized medical equipment and supplies must be specified in the plan of care and must enable individuals to increase their abilities to perform activities of daily living or to perceive, control or communicate with the environment in which they live. Without the equipment or supply, the individual would require institutionalization. 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**.**

13.29.A SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES COVERED ITEMS

Includes devices, controls or appliances that increase a person's ability to perform activities of daily living, items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State plan.

(For Comprehensive and Community Support Waivers: Includes equipment, supplies and equipment repairs that are not covered under the Medicaid State DME plan).

13.29.B SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES PROVIDER REQUIREMENTS

Providers of specialized medical equipment and supplies *must* have a DMH Home and Community Based Medicaid Waiver contract specific to the provision of the specialized medical equipment and supplies. The company *must* also be registered and in good standing with the Missouri Secretary of State's Office.

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13.29.C SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES SERVICE LIMITATIONS

Specialized medical equipment and supplies are limited to $5,000 per year, per participant.

13.29.D SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES UNIT OF SERVICE

- **Medicaid procedure code:**
- **Comprehensive Waiver: T2029HI**
- **Lopez Waiver: T2029HI**
- **Community Support Waiver: T2029U1**
- **Unit of Service: one item or adaptation**
- **Maximum expenditure: $5,000 of items or adaptations per individual per year**

13.29.E SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES SERVICE DOCUMENTATION

Specialized Medical Equipment providers shall maintain documentation as described in 13.10.A of this manual as it applies to this service. The MRDD Regional Center must be provided with an itemized invoice documenting items purchased and/or installed, prior to billing

13.30 SUPPORTED EMPLOYMENT (Comprehensive and Community Support)

Supported employment is competitive work in an integrated work setting with on-going support services for individuals with severe disabilities for whom competitive employment either has never been possible or has been interrupted as a result of the disability. The service *must* be based on a supported employment assessment and *must* be prescribed in a person centered plan. In the context of supported employment, competitive work is defined as a full or half time job, for which the individual is paid in accordance with the Fair Labor Standards Act. An integrated work setting is one in which workers with disabilities are, to the greatest extent possible, integrated with persons who do not have disabilities. Ongoing support consists of continuous or periodic job skill training provided at least twice monthly at the work site to enable the individual to perform the work**.**

13.30.A SUPPORTED EMPLOYMENT INCLUDED SERVICES

Supported Employment services may be provided individually or to groups of individuals and may include:

- assessment;
- counseling;
- job development and placement;
- on-the-job training in work and work-related skills;
- ongoing supervision and monitoring of the person's performance on the job; and

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

13.30.B RECIPIENT ELIGIBILITY FOR SUPPORTED EMPLOYMENT

The waiver does not cover vocational rehabilitation services that are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore, the case records for individuals receiving supported employment services under the waiver must document that the person was denied benefits by the Division of Vocational Rehabilitation (DVR), exhausted DVR Benefits (nine months is the maximum in Missouri), the individual required services not covered by DVR or the individual requests support from a provider that does not participate in DVR's system. The service coordinator's documentation of DVR's failure to confirm a denial of benefits in writing within 30 days of verbal notification may also serve as evidence of eligibility for waivered supported employment.

13.30.C SERVICE APPROACHES

13.30.C(1) Individual

The job coach model establishes employment opportunities for individuals with severe disabilities in local industries on a one-person/one-job basis for jobs at or above commensurate wages. A trained job coach develops the job in the industry, matches an individual to the job, trains the individual until they meet industry criteria and provides on-going follow-up support to the individual and the employer for as long as such services are required. The job coach should seek to shift reliance from the job coach to others within the work setting (natural supports).

13.30.C(2) Group

A supported employment enclave maintains many of the benefits of integrated employment while providing the continuous on-going support required by some individuals for long-term success. Small groups of workers, of not more than eight, with severe disabilities are employed in an industrialized setting managed by a specially trained supervisor. With the enclave, payment for work performed is commensurate with pay to others within the host company doing the same type and amount of work. Persons with disabilities work alongside others doing the same work, although limited work abilities and behavioral needs may require that workers be situated in proximity of each other to enhance training and supervision. Workers with disabilities receive the same benefits as others in the company with respect to such procedures as working hours, lunch and break times and performance evaluations.

As with the enclave model, the mobile crew provides the opportunity for continuous, on-going support while offering integrated employment. A small crew or set of crews has one supervisor with not more than eight per crew performing work in regular industry. Typically, the workers in a mobile crew perform service operations for organizations, businesses and individual community members.

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13.30.D SUPPORTED EMPLOYMENT STAFF REQUIREMENTS

All direct-care staff *must:*

- Must be 18 years of age

And have the following

- a high school diploma or its equivalent*;
- current certification in a competency based CPR/First Aid Course;
- training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care;
- training in the implementation of *(each consumer's)* person centered plan (within one month of employment) *(effective 9/1/07)* and training in a positive behavior support curriculum approved by the Division of MRDD (within 3 months of employment);
- Additionally, staff administering medication supervising self-administration of meds must have successfully meet the requirements of 9CSR 45-3.070.

*Exemptions to H.S. diploma/GED requirement

13. Staff without diplomas or GEDs employed by the same provider prior to 7-1-96 are "grandfathered."
14. Staff without diplomas or GEDs may be employed for up to one year, while the person works to attain the requirement. The provider *must* document the staff's enrollment in school or GED courses
15. After 7-1-96, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional center. The provider is responsible for maintaining documentation of the five years of experience and of regional center agreement in the employee's file.

13.30.E SUPPORTED EMPLOYMENT PROVIDER REQUIREMENTS

Providers *must* have a DMH Home and Community Based Medicaid Waiver contract for the provision of supported employment services and *must* have one of the following:

- A valid DMH license under 9 CSR 45-5.010 or certification by DMH under the Code of State Regulations, 9 CSR 45-5.010;
- Accreditation by the Commission on Accreditation of Rehabilitation Facilities
- (CARF) in the area of Community Employment Services; or
- The Council for Quality & Leadership for Persons with Developmental Disabilities (The Council).

13.30.F SUPPORTED EMPLOYMENT UNIT OF SERVICE

13.30.F(1) Individual

- Medicaid procedure codes:
- Comprehensive Waiver: H2023HI
- Community Support Waiver: H2023U1
- Unit of Service: 15 minutes

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- Maximum units: 32/day

13.30.F(2) Group

- Medicaid procedure codes:
- Comprehensive Waiver: H2023HIHQ
- Community Support Waiver: H2023U1HQ
- Unit of Service: 15 minutes
- Maximum units: 32/day

13.30.G SUPPORTED EMPLOYMENT SERVICE DOCUMENTATION

Support Employment providers *must* document progress as referenced in Section 13.10.A. of this manual. Providers *must* also document hours worked, wages earned and deductions taken; and periodically assess the continued presence and extent of involvement of the job coach as part of the review process. Written data shall be submitted to DMH authorizing staff as required.

13.31 PERSONAL ASSISTANT SERVICES (Comprehensive, Community Support, and Lopez)

Personal assistant services include assistance with any activity of daily living (ADL) or instrumental activity of daily living (IADL). Assistance for ADLs include bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, care of adaptive equipment, meal preparation, feeding and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation and leisure activities and assistance with IADLs includes accompaniment, coaching and minor problem-solving necessary to achieve increased independence, productivity and inclusion in the community. While ordinarily provided on a one-to-one basis, personal assistance may include assisting up to three individuals at a time.

For the Comprehensive Waiver and Community Support Waiver only, the Regional Center Director may give an exception in writing for a group size of 4 to 6 when it is determined the collective needs of the specific persons to be served in the group can be safely met. An example of when an exception may be considered is for a group of individuals in a congregate or conjoined living arrangement that is not a DMH community placement. Each person requires oversight overnight while sleeping and may also require assistance in being turned, and/or changed.

Personal assistance may also include general supervision and protective oversight. The personal assistant may directly perform some activities and support the individual in learning how to perform others; the planning team determines the composition of the service and assures it does not duplicate, nor is duplicated by, any other service provided to the individual.

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Personal Assistance, Specialized Medical/Behavioral (*Effective 9/1/07)*

Specialized medical/behavioral personal assistance includes services (listed under 13.31) to a consumer who has certain medical or behavioral needs. Due to these enhanced needs there are additional requirements that must be met prior to this service being implemented.

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

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

The specialized behavioral/medical personal assistant *must* adhere to the same requirements as outlined in Section 13.31.A(5) for the Individual Provider Employed by Consumer or Family Additional requirements are as follows:

Specialized Behavioral Personal Assistant:

- Received training and holds current certification on behavioral support intervention that is approved by DMH and;
- Agency QMRP has participated and successfully completed a DMH approved Positive Behavior Support Training and;
- Must be trained on the specific consumer's behavior support plan.

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

- The interdisciplinary team has identified that the consumer's level of care requires either the:
  - Direct delivery of care by a licensed medical professional* or,
  - Training, delegation and periodic supervision of care by a licensed medical professional*.

The person centered plan documents the need and timeline for review of service.

The specialized medical personal assistant *must* adhere to the same requirements as outlined in Section 13.31.A(5) for the Individual Provider Employed by Consumer or Family. Additional requirements are as follows:

Specialized Medical Personal Assistance:

- Received training related to the individual's medical needs as outlined in the Person Centered Plan 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.
- All training is documented and available upon request.

* Licensed Medical Professional as defined by the Nursing Practice Act Chapter 335. RSMo.

13.31.A PERSONAL ASSISTANT PROVIDER REQUIREMENTS

Personal assistance may be provided either by an individual worker employed by the consumer or family, and individual contractor, or by an employee of an agency. The determination of which type of provider delivers the service is the choice of the consumer and/or family or guardian, with the limitation that for an individual provider to be used, the consumer and/or family or guardian must be able and willing to supervise the provider and the planning team *must* certify that this supervision is sufficient to safeguard the individual's health and safety.

13.31.A(1) Provider Supervision

Supervision is provided by a QMRP or by the consumer or the consumer's family or guardian. In cases, the frequency and scope of the supervision is specified in the plan of care.

13.31.A(2) Relatives as Providers

(a) For the Sarah Lopez Waiver only:

Personal assistant services provided to a person by a member(s) of the person's immediate family (natural, half- or step-relationships with parent, child, sibling or spouse) may not be reimbursed under the wavier. Other persons related to the consumer may provide this service under the waiver if they meet the same age and training requirements as other providers. There must be a determination by the planning team,

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documented in the person's plan, that such an arrangement best meets the particular needs of the individual.

(b) For the Comprehensive and Community Support Waiver Only:

Personal assistant services may not be provided by an individual's spouse or if the individual is a minor (under age 18) by a parent. Personal assistant services may otherwise be provided to a person by a member(s) of his or her family when:

- The person is not opposed to the family member providing the service
- The service to be provided does not primarily benefit the family unit
- The service is not a household task family members expect to share or do for one another when they live in the same household
- Otherwise is above and beyond typical activities family members provide for another adult family member without a disability.

Additionally, the following conditions, documented in the person's plan, must be met:

- The service would otherwise need to be provided by a qualified provider
- A qualified provider who is not a family member is not available to provide the service or can only provide the service at an extraordinarily higher cost than the fee or charge negotiated with the qualified family member; and
- The planning team determines the family member providing the personal assistant service will best meet the individual's needs.

Only the hours of service determined necessary through the assessment and person centered planning process may be authorized and the authorized units of care may fluctuate based on the needs of the individual. Family members providing paid care shall not be guaranteed a set number of hours to ensure the family member a steady income.

Family members approved to provide personal assistant services may be employed by an agency or employed by the person/family using an approved fiscal intermediary. A family member approved to provide personal assistant services shall not also be the person's legal representative (guardian). If the person employs his/her own workers using an approved fiscal intermediary, the family member serving as a paid personal assistant shall not also be the employer of record. Family members may not be authorized and paid for overtime. The DMRDD may establish annually a maximum allowable rate to be paid to family members.

Family members approved to provide personal assistant services shall meet the same age, training, education, monitoring, background check, documentation requirements, etc. as any other individual provider. If employed by an agency, all employee requirements must be met.

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13.31.A(3) Relation to State Plan Services

When an individual's need for personal assistance is strictly related to ADLs and can be met through the Medicaid state plan Personal Care Program, the individual is not eligible for personal assistant services under the waiver, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. However, personal care services under the state plan differ in service definition, in limitations of amount and scope and in provider type and requirements from personal assistant services under the waiver.

13.31.A(4) Non-Duplication of Services

Personal assistance is not available to waiver consumers who reside in community residential facilities (Group Homes and Residential Care Centers) or who receive Individualized Supported Living (ISL) services, when the personal assistant services duplicate the residential habilitation services being provided under those models. Exceptions may be approved by the regional center when the planning team can show the need and efficiency of combining these services and can document that no duplication of payment would result.

13.31.A(5) Individual Provider Employed by Consumer or Family

An individual provider of personal assistance may, if the provider falls outside the federal definition of "domestic service worker," (and is, therefore, responsible for his or her own tax withholdings), enroll directly with the Medicaid Program or with an Organized Health Care Delivery System to provide this service.

Most personal assistants, however, fall into the category of "domestic service worker," and someone needs to be that worker's employer. The state considers such individual providers the employee of the consumer or family for whom they work, but rather than holding the consumer or family responsible for withholding taxes and performing all other required employer functions, it contracts with fiscal intermediaries to perform some or all of these functions on their behalf.

The employee of the consumer/family must have agreements with DMRDD and with the consumer/family.

All direct-care staff *must*:

- Must be 18 years of age

And have the following

- a high school diploma or its equivalent*;
- current certification in a competency based CPR/First Aid Course;

- training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care;
- training in the implementation of *(each consumer's)* person centered plan (within one month of employment) *(effective 9/1/07)* and training in a positive behavior support curriculum approved by the Division of MRDD (within 3 months of employment);
- Additionally, staff administering medication supervising self-administration of meds must have successfully meet the requirements of 9CSR 45-3.070.

*Exemptions to H.S. diploma/GED requirement

16. Staff without diplomas or GEDs employed by the same provider prior to 7-1-96 are "grandfathered."
17. Staff without diplomas or GEDs may be employed for up to one year, while the person works to attain the requirement. The provider *must* document the staff's enrollment in school or GED courses
18. After 7-1-96, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional center. The provider is responsible for maintaining documentation of the five years of experience and of regional center agreement in the employee's file.

The planning team specifies the qualifications and training the personal assistant needs in order to carry out the plan, where/by whom the attendant is trained and the source, method and degree of monitoring. To the extent they desire, the consumer and the consumer's family/guardian selects the personal assistant and carries out training and supervision.

- Procedures and expectations related to the personal assistant, including following the person centered plan, the rights and responsibilities of the provider and the consumer, procedures for billing and payment, reporting and record keeping requirements, procedures for arranging backup when needed and who to contact within the regional center.
- Information about the specific condition and needs of the person to be served, including the person's physical, psychological or behavioral challenges, capabilities and support needs and preferences related to that support.
- As needed, training in communications skills; in understanding and respecting consumer choice and direction; in respecting the consumer's confidentiality, cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints and in responding to emergencies.
- Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the consumer and identified by the team.

The consumer or the consumer's family or guardian must approve the selection of the personal assistant and a Client Choice of Provider Statement to this effect is maintained by the regional center. A checklist of the training provided (when, by whom and topics

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covered) is maintained with the statement. With the agreement of the consumer, the consumer's family or guardian, the regional center may exempt a prospective personal assistant provider from those parts of the required minimum training where the assistant is judged to possess adequate knowledge or experience or where the assistant's duties do not require those particular skills. This exemption must be specified on the checklist maintained with the Client Choice of Provider Statement.

13.31.A(6) Independent Contractor

Persons who are licensed in Missouri to provide healthcare and/or behavior support services, such as a Registered Nurse or Psychologist, may become an independent contractor of specialized medical/behavioral level of personal assistant services. Independent contractors for medical/behavioral personal assistant services must have a contract with DMH and/or provide services through an Organized Health Care Delivery system.

The contractor shall not be the consumer's spouse, a parent of a minor child (under age 18), nor a legal guardian.

The contractor must be trained as specified for the individual employed by the consumer/family above. In addition, the planning team may specify additional qualifications and training necessary to carry out the plan.

13.31.A(7) Individual Employed by an Agency

An agency-based provider must be employed by one of the following:

- A DMH-certified or CARF/The Council-accredited provider of Individualized Supported Living Services;
- A DMH-licensed or certified or CARF/The Council-accredited provider of Day Habilitation Services;
- A Medicaid-enrolled provider of personal care services which employs, contracts with or otherwise arranges for a QMRP to direct or consult with its personal assistance operations; or
- A temporary employment agency whose employee is trained and supervised by the family or consumer in accordance with the requirements for an individual provider.

The agency-based provider of personal assistance *must* adhere to the same requirements as outlined in Section 13.31.A(5) for the Individual Provider Employed by Consumer or Family.

The agency-based provider of personal assistance must be trained and supervised in accordance with the certification or program enrollment requirements that apply. In

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addition, the planning team may specify additional qualifications and training necessary to carry out the plan. A QMRP supervises the personal assistant.

13.31.B PERSONAL ASSISTANT LIMITATION

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 the individual's plan. There is no restriction on the place of service**.**

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.

13.31.C PERSONAL ASSISTANT UNIT OF SERVICE

13.31.C(1) Personal Assistant, Individual Provider IND Consumer Directed

- Medicaid procedure code:
- Comprehensive Waiver: T1019HIU2
- Lopez Waiver: T1019HIU2
- Community Support Waiver: T1019U1U2
- Unit of Service: 15 Minutes
- Maximum units: 96 Units/day

13.31.C(2) Personal Assistant, Agency

- Medicaid procedure code:
- Comprehensive Waiver: T1019HI
- Lopez Waiver: T1019HI
- Community Support Waiver: T1019U1
- Unit of Service: 15 Minutes
- Maximum units: 96 Units/day

13.31.C(3) Personal Assistant, Group

- Medicaid procedure code:
- Comprehensive Waiver: T1019HIHQ
- Lopez Waiver: T1019HIHQ
- Community Support Waiver: : T1019U1HQ
- Unit of Service: 15 Minutes
- Maximum units: 96 Units/day

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13.31.C(4) Personal Assistant, Group Size 4-6, Requires Exception

- Medicaid procedure code:
- Comprehensive Waiver: T1019HIHQ
- Community Support Waiver: T1019U1HQ
- Unit of Service: 15 Minutes
- Maximum units: 96 Units/day

13.31.C(5) Personal Assistant, Specialized Medical/Behavioral, Consumer Directed

- Medicaid procedure code:
- Comprehensive Waiver: T1019HITGSE
- Lopez Waiver: T1019HITGSE
- Community Support Waiver: T1019U1TGSE
- Unit of Service: 15 Minutes
- Maximum units: 96 Units/day

13.31.C(6) Personal Assistant, Specialized Medical/Behavioral, Agency/Contractor

- Medicaid procedure code:
- Comprehensive Waiver: T1019HITG
- Lopez Waiver: T1019HITG
- Community Support Waiver: T1019U1TG
- Unit of Service: 15 Minutes
- Maximum units: 96 Units/day

13.31.D PERSONAL ASSISTANT SERVICE DOCUMENTATION

Personal Assistant providers must maintain documentation as referenced in Section 13.10.A. of this manual. When the personal assistant's employer of record is the consumer or the consumer's family, the consumer or family is responsible for ensuring adequate documentation in accordance with Section 13.10.A. is maintained. Written data shall be submitted to DMH authorizing staff as required.

13.32 CRISIS INTERVENTION (Comprehensive, Community Support, and Lopez)

Crisis intervention is immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from the current living arrangement. Crisis intervention may be provided in any setting and includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and to provide additional direct services as needed to stabilize the situation.

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Individuals with developmental disabilities are occasionally at risk of being moved from their residences to institutional settings because the person or family members or other caretakers are unable to cope with short term, intense crisis situations. Crisis intervention can respond intensively, with relief, alternatives and resources to resolve the crisis and prevent the dislocation of the person at risk. The consultation that is provided to caregivers also helps to avoid or lessen future crises.

Crisis intervention services are expected to be of brief duration (four to eight weeks, maximum). When services of a greater duration are required, the individual should be transitioned to a more appropriate service program such as counseling, behavior therapy or respite.

13.32.A CRISIS INTERVENTION SERVICE COMPONENTS

Crisis intervention service components may include the following:

- Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis. Acting-out behavior is usually a form of communication and the intervener has to be able to understand the message;
- Assessing which components are the most effective targets of intervention for the short-term amelioration of the crisis;
- Developing and writing an intervention plan which may focus on the individual, on those around the individual and/or on more remote ecological issues such as housing, day program or workshop. The purpose of the interventions is to keep all parties from harm and maintain the individual in the individual's chosen living, working, social and/or educational environment;
- Consulting and, in some cases, negotiating with those connected to (affecting and/or affected by) the crisis in order to implement planned interventions and following-up to ensure positive outcomes from interventions or to make adjustments to interventions;
- Providing intensive direct supervision when an individual is physically aggressive or there is concern that the individual may take actions that threaten the health and safety of self and others. This supervision may also seek to modify inappropriate behavior, attitudes or habits that prevent or interfere with the individual's inclusion in activities with 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; and
- Directly counseling or developing alternative positive experiences for individuals who experience severe anxiety and grief when changes occur with job, living arrangement, primary caregiver, death of loved one, etc.

13.32.B CRISIS INTERVENTION PROVIDER REQUIREMENTS

Providers of crisis intervention shall consist of a team under the direction and supervision of a psychologist, counselor or social worker licensed by the State of Missouri (RSMo 1994, Chapter 337). Alternately, the supervisor may be employed

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by the State of Missouri as a psychologist, clinical social worker or in an equivalent position (such positions are exempt from licensure) and meet the requirements of a QMRP as defined in Section 13.17 of this manual. All team members shall have at least a high school diploma or its equivalent* and at least one year of work experience in serving persons with developmental disabilities. In addition, team members shall, either within their previous work experience or separately, have a minimum of 40 hours training in crisis intervention techniques prior to providing services.

Crisis teams may be agency based (certified or accredited ISL lead agencies, day habilitation providers and group homes or DMRDD regional centers and habilitation centers) or they may stand alone. However, no provider of residential services may be reimbursed for providing crisis intervention services to an individual for whom they are paid a per diem rate. Crisis teams may either enroll with the Medicaid agency (which requires submitting a purchase of service RFP to the DMH) or execute a specialized waiver contract with the DMRDD regional center (operating as an Organized Health Care Delivery System).

*Exemptions to H.S. diploma/GED requirement

1. Staff without diplomas or GEDs employed by the same provider prior to 7-1-96 are "grandfathered."
2. Staff without diplomas or GEDs may be employed for up to one year, while the person works to attain the requirement. The provider must document the staff's enrollment in school or GED courses
3. After 7-1-96, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional center. The provider is responsible for maintaining documentation of the five years of experience and of regional center agreement in the employee's file

13.32.C CRISIS INTERVENTION UNIT OF SERVICE

13.32.D(1) Professional

- Medicaid procedure code:
- Comprehensive Waiver: S9484HI
- Lopez Waiver: S9484HI
- Community Support Waiver: S9484U1
- Unit of Service: One Hour
- Maximum units: 24/day

13.32.D(2) Technician

- Medicaid procedure code:
- Comprehensive Waiver: S9484HIHM
- Lopez Waiver: S9484HIHM
- Community Support Waiver: S9484U1HM

- Unit of Service: One Hour
- Maximum units: 24/day

13.32.D CRISIS INTERVENTION SERVICE DOCUMENTATION

Crisis Intervention providers are required to follow documentation procedures set forth in Section 13.10.A of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the consumer's person centered plan, service plan or plan of care. Written data shall be submitted to DMH authorizing staff as required.

13.33 COMMUNITY SPECIALIST SERVICES (Comprehensive, Community Support and Lopez)

Community specialist services include professional observation and assessment, individualized program design and implementation and consultation with caregivers, coordination with all agencies involved with the individual and monitoring and evaluation of service outcomes. This service may also, at the choice of the consumer or family, include advocating for the consumer and assisting the consumer in locating and accessing services and supports.

The provider must meet QMRP qualifications and be free of any conflict of interest with other providers serving the consumer. The services of the community specialist assist the consumer and the consumer's caregivers to design and implement specialized programs to enhance self direction, independent living skills, community integration, social, leisure and recreational skills and behavior management. A community specialist with expertise in person centered planning may also be selected by the consumer to facilitate the interdisciplinary planning team meeting**.**

13.33.A COMMUNITY SPECIALIST PROVIDER REQUIREMENTS

Providers of community specialist services must meet QMRP qualifications as defined in Section 13.17 of this manual. The service may be provided by either an individual provider or an employee of an agency. There is an additional consumer directed option for the comprehensive and community support that allows the QMRP- qualified community specialist to be an employee of the consumer or family. The determination of which type of provider delivers the service is the choice of the individual and/or family or guardian.

13.33.A(1) Individual Contractor

The individual contractor of community specialist services may either enroll with the Medicaid agency (which requires submitting a purchase of service RFP to the Department of Mental Health) or execute a specialized waiver contract with the DMRDD regional center (operating as an Organized Health Care Delivery System).

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In either case, the provider must meet QMRP qualifications as defined in Section 13.17 of this manual, which are verified by the DMRDD regional center and the DMH contracts administration unit before a contract is finalized.

13.33.A(2) Employee of an Agency

An agency-based provider of community specialist services must be employed by one of the following agencies:

- Certified by DMH under 9 CSR 45.5.010 or accredited by CARF or ACD as a lead agency for Individualized Supported Living Services;
- Certified by DMH under 9 CSR 45.5.010 or accredited by CARF or ACD as a provider of Day Habilitation Services; or
- Medicaid-enrolled provider of personal care services which employs a QMRP to direct or consult with its personal assistance operation.

13.33.A(3) Individual Provider Employed by Consumer or Family (Comprehensive and Community Support Waivers only)

Providers of community specialist services must meet QMRP qualifications as defined in Section 13.17 of this manual. The state will consider such individual providers the employee of the consumer or family for whom they work, but rather than holding the consumer or family responsible for withholding taxes and performing all other required employer functions, it will contract with a fiscal intermediary to perform some or all of these functions on their behalf. The community specialist will have skills and experience in the following areas, at a minimum, in order to best meet the needs of the consumer as identified by the planning team:

- Principles of self-determination
- Individual choice and self-direction (including risks and responsibilities)
- Consumer rights and confidentiality
- Community Specialist functions (as described in the service definition):
  - Application of person-centered planning in self-directed supports and services
  - Identify specific needs, preferences, goals for the person to be served
  - Person-Centered Planning and program design and implementation
  - Facilitating planning meetings as identified
  - Training for consumers and families as identified
  - Consultation with agencies
  - Program/services evaluation
  - Identify, explore and access needed community supports and resources

The consumer, his or her family or guardian must approve the selection of the community specialist, and a Client Choice Statement to this effect will be maintained by the regional center. A checklist of the training provided (when, by whom, and topics covered) will be maintained with the Client Choice Statement.

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13.33.B COMMUNITY SPECIALIST SERVICE LIMITATION

The planning team shall first ensure that provision of this service does not duplicate the provision of any other services. A community specialist who facilitates the planning meeting for a person shall not have any conflict of interest with any provider who may wish to serve the person.

13.33.C COMMUNITY SPECIALIST UNIT OF SERVICE

- Medicaid procedure code:
- Comprehensive Waiver: T1016HI
- Consumer-Directed-Comprehensive Waiver T1016HIU2
- Lopez Waiver: T1016HI
- Community Support Waiver: T1016U1
- Consumer-Directed-Community Support Waiver T1016UIU2
- Unit of Service: 15 minutes
- Maximum units: 96 units/day

13.33.D COMMUNITY SPECIALIST SERVICE DOCUMENTATION

Community Specialist providers must maintain documentation as referenced in Section 13.10.A of this manual, including plan of treatment and detailed record of intervention activity by unit to include referrals to other agencies, recommendations for treatment change, progress on behavioral/service objectives which are part of the person centered plan. Annual assessments of consumer/family status are required. When the Community Specialist's employer of record is the consumer or the consumer's family, the consumer or family is responsible for ensuring adequate documentation in accordance with Section 13.10.A. is maintained. Written data shall be submitted to DMH authorizing staff as required.

13.34 COMMUNICATION SKILLS INSTRUCTION (Comprehensive and Community Support)

Communication skills instruction is a service to train individuals with minimal language skills (MLS) to use systematic communication. Individuals with MLS are persons who are deaf who know neither English nor American Sign Language (ASL), nor have any other formal communication system. Typically, persons with MLS were born deaf or became deaf before they learned a language, never have spoken and are diagnosed or labeled as having mental retardation. Through assessment and training, some are able to learn to speak and nearly all are able to learn and use ASL. Under the waiver, this service is used to help individuals with multiple developmental disabilities communicate with the people around them, a critical skill for community survival and exercising choice and self determination.

Communication skills instruction includes both assessment/evaluation and training. An initial assessment of an individual's communication skills is performed to determine the need for instruction. It measures the number of ASL or home signs used; finger spelling

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capacity; degree of "parroting;" use of gesture, mime, writing on paper; attention span; facial expressions; and consistency in communication with a variety of others, both deaf and hearing. Evaluation of the outcome of the instruction occurs at six-month intervals: this includes evaluation of communication skills in social, vocational and leisure situations, behavioral changes and need for continued instruction and/or other intervention.

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

13.34.A COMMUNICATION SKILLS INSTRUCTION PROVIDER REQUIREMENTS

This service may be provided by persons certified as Communication Development Specialists by the DMH, Office of Deaf Services. Certification is granted based on completion of a prescribed course of study offered through local interpreter training programs or during extended workshops held by the Bureau. The certified Communication Assistant may either enroll with the Medicaid agency or execute a specialized waiver contract with the DMRDD regional center (operating as an Organized Health Care Delivery System).

13.34.B COMMUNICATION SKILLS UNIT OF SERVICE

- Medicaid procedure code:
- Comprehensive Waiver: H2014HI
- Community Support Waiver: H2014U1
- Unit of Service: 15 Minutes
- Maximum units: 32 Units/day

13.34.C COMMUNICATION SKILLS INSTRUCTION SERVICE DOCUMENTATION

Communication Skills providers must maintain service documentation as described in Section 13.10.A of this manual.

13.35 COUNSELING (Comprehensive, Community Support, and Lopez)

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, 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

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Healthy Children and Youth (EPSDT) Program. Counseling under the waiver includes psychological testing, initial assessment, periodic outcome evaluation and coordination with family members, caretakers and other professionals in addition to direct counseling. This service is needed by certain waiver participants whose living arrangement, job placement or day activity is at risk due to maladaptive behavior or lack of adjustment. The planning team ensures this service does not duplicate, nor is duplicated by, any other services provided to the individual.

13.35.A COUNSELING PROVIDER REQUIREMENTS

The provider must be a psychologist, counselor or social worker licensed in accordance with RSMo 1994, Chapter 337.

13.35.B COUNSELING UNIT OF SERVICE

- Medicaid procedure code:
- Comprehensive Waiver: H0004HITG
- Lopez Waiver: H0004HITG
- Community Support Waiver: H0004U1TG
- Unit of Service: 15 minutes
- Maximum units: 32/day

13.35.C COUNSELING SERVICE DOCUMENTATION

Counseling providers must maintain documentation as described in Section 13.10.A of this manual.

13.36 COMMUNITY TRANSITION (Comprehensive Only)

Transition services are one-time, set-up expenses for individuals who transition from an institution (ICF/MR or Title XIX Nursing Home) to a home, apartment, or other community-based living arrangement. This service is limited to persons who transition from a Title XIX institutional setting to the MRDD Comprehensive Waiver.

Examples of expenses that may be covered include:

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

Essential furnishings include items for an individual to establish his or her basic living arrangement, such as a bed, a table, chairs, window blinds, eating utensils, and food

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preparation items. Essential furnishings do not include diversional or recreational items such as televisions, cable TV access, VCR or DVD player/recorders**.**

13.36.A COMMUNITY TRANSITION PROVIDER REQUIREMENTS

Community Transition service may be provided by an individual contractor or agency based..
Qualified agency based providers must have a current DMH Home and Community Based waiver contract for the provision of independent supported living (ISL) services, residential habilitation services, or day habilitation; or must be a Division of Mental Retardation and Developmental Disabilities Regional Center enrolled as a Medicaid waiver provider. An agency contractor with an applicable business license for the service provided and is registered with good standing with the Missouri Secretary of State may also provide this service.

13.36.B COMMUNITY TRANSITION SERVICE LIMITATION

The services must be necessary for the person to move from an institution. The need for specific transition services must be documented in the individual's person centered plan. Total transition services are limited to $3,000 per participant in the process of moving from a Title XIX institution to the community**.**

13.36.C COMMUNITY TRANSITION UNIT OF SERVICE

- Medicaid procedure code:
- Comprehensive Waiver: T2038HI
- Unit of Service: 1-job
- Maximum units: 1-month

13.36.D COMMUNITY TRANSITION DOCUMENTATION

Community Transition providers shall maintain documentation as described in 13.10.A of this manual as it applies to this service. The MRDD Regional Center ***must*** **be provided with invoices documenting items and/or services purchased, prior to billing.**

13.37 SUPPORT BROKER (Comprehensive and Community Support Waiver only)

A Support Broker assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to remain independent. Examples of skills training include providing information on recruiting and hiring personal assistant workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to assure that participants and their

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families understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the service plan

The Support Broker may provide the participant with information about:

- Person centered planning and how it is applied;
- The range and scope of individual choices and options;
- The process for changing the plan of care and individual budget;
- The appeal process;
- Risks and responsibilities of self-direction;
- Free choice of providers;
- Individual rights;
- Reassessment and review schedules; and
- Other subjects pertinent to the participant and/or family in managing and directing services.

The Support Broker may provide the participant with assistance:

- Defining goals, needs and preference, identifying and accessing services, supports and resources;
- Practical skills training (recruiting, hiring, managing, terminating workers, managing and approving timesheets, problem solving, conflict resolution)
- Development of risk management agreements;
- Development of an emergency back up plan;
- Recognizing and reporting critical events;
- Independent advocacy, to assist in filing grievances and complaints when necessary; and
- Other areas related to managing services and supports.

13.37.A SUPPORT BROKER PROVIDER REQUIREMENTS

Support broker may be provided either by an individual worker employed by the consumer or family,), or by an employee of an agency. The determination of which type of provider will deliver the service will be the choice of the consumer and/or his or her family or guardian, with the limitation that for an individual provider to be used, the consumer and/or family or guardian must be able and willing to supervise the provider. Support brokers must be at least 18 years of age and possess a high school diploma or GED.

13.37.A(1) Relatives as Providers

Support broker services may not be provided by an individual's spouse or if the individual is a minor (under age 18) by a parent. Support broker services may otherwise be provided to a person by a member(s) of his or her family when:

- The person is not opposed to the family member providing the service
- The service to be provided does not primarily benefit the family unit

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Additionally, the following conditions, documented in the person's plan, must be met:

- The service would otherwise need to be provided by a qualified provider
- A qualified provider who is not a family member is not available to provide the service or can only provide the service at an extraordinarily higher cost than the fee or charge negotiated with the qualified family member; and
- The planning team determines the family member providing the support broker service will best meet the individual's needs.

Family members approved to provide support broker services may be employed by an agency or employed by the person/family using an approved fiscal intermediary. A family member approved to provide support broker services shall not also be the person's legal representative (guardian). If the person employs his/her own workers using an approved fiscal intermediary, the family member serving as a paid support broker shall not also be the employer of record.

13.37.A(2) Individual Provider Employed by Consumer or Family

The state will consider such individual providers the employee of the consumer or family for whom they work, but rather than holding the consumer or family responsible for withholding taxes and performing all other required employer functions, it will contract with a fiscal management service to perform some or all of these functions on their behalf.

13.37.A(3) Individual Employed by an Agency

An agency-based provider must be employed by one of the following:

- Certified by DMH under 9 CSR 45-5.010 or accredited by CARF or ACD as a lead agency for Individualized Supported Living Services;
- Certified by DMH under 9 CSR 45-5.010 or accredited by CARF or ACD as a provider of Day Habilitation Services; or
- A Medicaid-enrolled provider of personal care services which employs, contracts with or otherwise arranges for a QMRP to direct or consult with its personal assistance operations
- A temporary employment agency whose employee is trained and supervised by the family or consumer in accordance with the requirements for an individual provider
- The planning team may specify additional qualifications and training necessary to carry out the plan. (See training topics)

13.37.A(4) Planning Team Responsibilities

For individuals who are employed by a family/consumer or employed by an agency, the planning team may specify the qualifications and training the support

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broker will need in order to carry out the individual's plan. Training topics for the planning team to consider for the Support Broker are as follows:

- Principles of self-determination
- Individual choice and self-direction (including risks and responsibilities)
- Consumer rights and confidentiality
- Application of person-centered planning in self-directed supports and services
- Support broker functions (as described above, related to information or assistance)

A checklist of the training provided (when, by whom, and topics covered) will be maintained with the Client Choice Statement.

13.37.B SUPPORT BROKER UNIT OF SERVICE

13.37.C(1) Support Broker, IND Consumer Directed

- Medicaid procedure code:
- Comprehensive Waiver: T2041HIU2
- Lopez Waiver:
- Community Support Waiver: T2041U1U2
- Unit of Service: 15 Minutes
- Maximum units: 32 Units/day

13.37.C(2) Support Broker, Agency /Contractor

- Medicaid procedure code:
- Comprehensive Waiver: T2041HI
- Lopez Waiver:
- Community Support Waiver: T2041U1
- Unit of Service: 15 Minutes
- Maximum units: 32 Units/day

13.37.C SUPPORT BROKER SERVICE DOCUMENTATION

Support Broker providers must maintain documentation as referenced in Section 13.10.A. of this manual. When the Support Broker's employer of record is the consumer or the consumer's family, the consumer or family is responsible for ensuring adequate documentation in accordance with Section 13.10.A. is maintained.

13.38 EXCEPTIONS (Community Support Only)

For participants in the Community Support Waiver only, exceptions to service limitations may be granted when the additional service is deemed necessary to

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protect the person's health and safety and/or to prevent the person from entering an institution. Exceptions may be approved by the Division of MRDD Director, or a designee, for a one time expense, or during a crisis, or a transition period. Individuals participating in the Community Support Waiver will not lose eligibility for the waiver due to an increased need for a covered service that causes the total need for that service or combination of services to exceed maximum amounts established by the state.

Examples of action the planning team may take to assist the person in accessing additional services that are required for health and safety and to avoid institutionalization are:

- Seek additional natural supports;
- Consider accessing non-waiver State or County (local) funds;
- Request approval for an exception from the Division of MRDD Director or designee, to exceed a maximum limitation for a one-time expense, or during a crisis or transition period; and/or
- Provide the person information regarding other Missouri waivers such as the MRDD Comprehensive waiver and provide assistance with applying and transitioning as needed.

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