

**Missouri Initial Spend Plan: Increased Federal Medical Assistance Percentage (FMAP)
under Section 9817 of the American Rescue Plan**

Initial HCBS Spending Plan Projection:

The initial HCBS spending plan projection should estimate the total amount of funds attributable to the increase in FMAP that the state anticipates claiming between April 1, 2021, and March 31, 2022, as well as the anticipated expenditures for the activities the state intends to implement to enhance, expand, or strengthen HCBS under the state Medicaid program between April 1, 2021, and March 31, 2024.

The following estimates represent only the enhanced earnings attributed to the 10% increase in FMAP for home and community based services between April 1, 2021 and March 31, 2022:

HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line	Projected Claiming
Home Health Care	Home health services are mandatory services authorized at section 1905(a)(7) of the Act, and defined in regulations at 42 C.F.R. § 440.70. Home health services include nursing services, home health aide services, medical supplies, equipment, and appliances, and may include therapy services (physical therapy, occupational therapy, speech pathology and audiology).	Line 12-Home Health Services	\$0.5M
Personal Care Services	Personal care services (PCS) are optional services authorized at section 1905(a)(24) and defined in regulations at 42 C.F.R. § 440.167. Personal care services can include a range of human assistance provided to persons who need assistance with daily activities. These services are provided to individuals who are not an inpatient or resident of a hospital, nursing facility (NF), intermediate care facility for individuals with intellectual disabilities (ICF/IID), or institution for mental diseases (IMD), and may be provided in the individual's home and, at state option, in other locations.	Line 23A- Personal Care Services- Regular Payment	\$40.0M
Self-Directed Personal Care Services	Section 1915(j) of the Act allows self-direction of state plan personal care services. Requirements are set forth in 42 CFR Part 441 Subpart J.	Line 23B- Personal Care Services-SDS 1915(j)	\$53.8M

Case Management	Case management services, as defined under sections 1905(a)(19) and 1915(g) of the Act and 42 CFR § 440.169 and 42 CFR § 441.18, assist Medicaid- eligible individuals in gaining access to needed medical, social, educational, and other services.	Line 24A- Targeted Case Management Services- Community Case Management Line 24B-Case Management State Wide	\$8.3M
School Based Services	These services include medical assistance for covered services under section 1905(a) that are furnished to a child with a disability because such services are included in the child's individualized educational program established pursuant to Part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan. Only school based services that meet the definition of one or more of the services listed in this appendix can be claimed at the increased FMAP under section 9817 of the ARP.	[This line is under development; further instructions will be issued.]	Awaiting further instructions
Rehabilitative Services	The rehabilitative services benefit is an optional Medicaid state plan benefit authorized at section 1905(a)(13) of the Act and codified in regulation at 42 CFR § 440.130(d) as “medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.” All rehabilitative services, including mental health and substance use disorder services, authorized under this benefit can be claimed at the increased FMAP under section 9817 of the ARP.	[This line is under development; further instructions will be issued.]	Awaiting further instructions

Private Duty Nursing ⁹	<p>Private duty nursing is an optional Medicaid state plan benefit authorized at section 1905(a)(8) of the Act and codified in regulation at 42 CFR § 440.80 as “nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided: (a) by a registered nurse or a licensed practical nurse; (b) under the direction of the recipient's physician; and (c) to a recipient in one or more of the following locations at the option of the State: (1) his or her own home; (2) a hospital; or (3) a skilled nursing facility.”</p> <p>The increased FMAP under section 9817 of the ARP is only applicable when the service is provided in a beneficiary’s own home, and is being included here based on the authority at ARP section 9817(a)(2)(B)(vii) given to the Secretary to specify additional services eligible for enhanced funding.</p>	[This line is under development; further instructions will be issued.]	Included in the 1915(c) waiver totals
Alternative Benefit Plans (Section 1937 of the Act)	Any of the Medicaid-covered services described under section 9817 of the ARP are eligible for the enhanced match when authorized under an approved Alternative Benefit Plan.	Follow CMS-64.9 Base Category of Service Definitions	N/A
Section 1915(c)	Waiver authority found at section 1915(c) of the Act gives states the option to offer long-term services and supports (LTSS) in home and community-based settings to individuals who would otherwise require institutional care. States have broad latitude to determine the services to offer under waiver programs, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act. For example, services may include home accessibility modifications (e.g., installing a wheelchair ramp or grab bars in a shower) to improve individuals’ ability to remain in their homes and prevent institutional admission.	Line 19A – Home and Community-Based Services – Regular Payment (Waiver)	\$114.2M

Section 1915(i)	Section 1915(i) is an optional state plan benefit that allows states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria (and, if chosen by the state, target group criteria) as set forth in 42 CFR Part 441 Subpart M. States have broad latitude to determine the services to offer under the section 1915(i) state plan benefit option, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act.	Line 19B- Home and Community-Based Services - State Plan 1915(i) Only Payment	N/A
Section 1915(j) – Self-directed 1915(c) services.	Section 1915(j) of the Act allows self-direction of HCBS otherwise available under a section 1915(c) waiver program that are provided to an individual who has been determined eligible for the self-directed option. Requirements are set forth in 42 CFR Part 441 Subpart J.	Line 19C- Home and Community-Based Services - State Plan 1915(j) Only Payment	N/A
Section 1915(k)	The section 1915(k) Community First Choice (CFC) state plan benefit provides certain individuals, who meet an institutional level of care, the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. States receive an extra six percentage points of federal match for CFC service expenditures. To the extent applicable, the increased FMAP under section 9817 of the ARP is additive to the increased FMAP specified in section 1915(k).	Line 19D- Home and Community Based Services State Plan 1915(k) Community First Choice	N/A
Program of All- Inclusive Care for the Elderly (PACE)	PACE provides comprehensive medical and social services to certain frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid. An interdisciplinary team of health professionals provides PACE participants with coordinated care.	Line 22- Programs Of All-Inclusive Care Elderly	N/A

Managed Long- Term Services and Supports	Managed long term services and supports (MLTSS) refers to the delivery of LTSS through capitated Medicaid managed care programs. Only the state plan and HCBS services defined in this appendix that are provided through a managed care delivery system are eligible for the enhanced FMAP referenced in this guidance. States can implement MLTSS using an array of managed care authorities, including a section 1915(a) voluntary program, a section 1932(a) state plan amendment, a section 1915(b) waiver, or a section 1115 demonstration. Any of those managed care authorities can be “paired” with other Medicaid authorities, such as section 1905(a), 1915(i), 1915(j), or 1915(k) or an HCBS waiver program under section 1915(c) to authorize HCBS benefits to be delivered through a managed care delivery system.	[This line is under development; further instructions will be issued.]	N/A
Section 1115	States can utilize section 1115(a) demonstration authority to test new strategies to promote the objectives of the Medicaid program that are not available under other authorities. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid requirements of section 1902 of the Act, including but not limited to statewideness and comparability, to the extent and for the period necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide FFP for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary. Any of the Medicaid-covered HCBS services described above are eligible for the enhanced match when authorized under an approved 1115 demonstration.	Follow CMS-64.9 Base Category of Service Definitions	N/A
Total Projected Claiming			\$216.8M

Activity	Activity Description	Projected Spending
Payment Rates	Increase rates for home health agencies, PACE organizations, and agencies or beneficiaries that employ direct support professionals (including independent providers in a self-directed or consumer- directed model) to provide HCBS under the state Medicaid program. CMS expects that the agency, organization, beneficiary, or other individuals that receive payment under such an increased rate will increase the compensation it pays its home health workers or direct support professionals. An increase to the PACE Medicaid capitation rate can be implemented as part of the state's regular annual rate update or on a temporary basis as an interim rate increase, but must comply with existing submission, review, and approval requirements. States are not permitted to provide supplemental funding to PACE organizations outside of the PACE Medicaid capitation payment due to regulatory requirements.	\$67M
New and/or Additional HCBS	Provide new or additional Medicaid HCBS services or increase the amount, duration, or scope of HCBS; funding must be used to supplement not supplant existing services.	\$50M
Strengthening Assessment and Person-Centered Planning Practices	Adopting standardized functional assessments. Enhancing person- centered planning practices. Providing person-centered planning training.	\$6M
Quality Improvement Activities	Upgrading critical incident management reporting systems. Adopting new HCBS quality measures. Implementing improvements to quality measurement, oversight, and improvement activities. Implementing the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) or another experience of care survey.	\$25M
Workforce Recruitment	Conduct activities to recruit and retain home health workers and direct support professionals. Offer incentive payments to recruit and retain home health workers and direct support professionals.	\$40.8M
Workforce Training	Provide training for home health workers and direct support professionals that is specific to the COVID-19 PHE.	

Employing Cross- system Data Integration Efforts	Establishing data sharing and governance agreements that enumerate standards and practices for data sharing among state and county agencies, providers, and community-based organizations such as with the National Adult Maltreatment Reporting System. Providing training and technical assistance to build providers' performance measurement and predictive analytics capabilities. Building a stronger health and welfare system by integrating claims and encounter data with the state's incident management system.	\$12M
Expanding Use of Technology and Telehealth	Making investments in infrastructure to facilitate incorporation of HCBS into interoperable electronic health records (EHRs). Covering individual tele-communications start-up costs (e.g., equipment, internet connectivity activation costs). Testing the impact of assistive technologies on the need for in-person supports. Providing smartphones, computers, and/or internet activation fees to address functional needs, promote independence, and/or support community integration.	
Adopting Enhanced care Coordination	Implementing health information technology care coordination enhancements such as notification systems and capabilities (e.g., hospital admission, discharge, and transfer notifications) to share information across different health care settings. Integrating Medicare and Medicaid data and/or improving Medicaid managed care plan access to Medicare data to improve care coordination for individuals receiving HCBS who are dually eligible for Medicare and Medicaid. Implementing integrated care models that can more effectively address the needs of complex populations.	\$9M
Admin Claiming	Technical assistance contracts and staff administration associated with the project implementation.	\$7M
Total Projected Spending		\$216.8M

Initial HCBS Spending Narrative:

Below is information regarding Missouri's scope of activities for the ARP section 9817 funding. Each initiative is organized by the "Activity Functions" defined within the CMS guidance. Missouri will explore various federal funding opportunities, state, and local resources to maintain these systems once the ARP funds are exhausted. Larger investments will require replacement with state funds (subject to appropriation). Missouri has considerable traction with investing in home and community based services, with and without large federal commitments, and sees this as an opportunity to ensure participants receive quality services, providers receive needed resources during the COVID-19 pandemic, and allows the state to develop new models of care.

Unless otherwise noted, these initiatives are subject to appropriation by the state's general assembly.

Recognizing that the projects listed below are significant efforts, Missouri requests that Enhanced HCBS FMAP be used for technical assistance contracts and staff administration associated with the project.

HCBS Provider Payment Rate and Benefit Enhancements

The general assembly has included appropriations in the State Fiscal Year 2022 budget for the following rate initiatives:

- Funding to standardize Division of Developmental Disability (DD) residential habilitation rates to the Mercer State Fiscal Year 2020 lower bound rates; and
- 5.29% temporary rate increases for DHSS HCBS providers (and corresponding increases to similar DD services) to increase compensation of direct care support professionals.

Any continuation of funding beyond SFY 2022 for these initiatives will require general assembly approval.

Missouri is interested in further increasing rates within the market value scale to support an increase in compensation of direct care support professionals. One example of this is an interest in funding to standardize DD employment rates to the Mercer State Fiscal Year 2020 lower bound rates which would also require approval from the general assembly.

Work Force Recruitment and Support

Additional provider payments could be leveraged to increase recruitment and retention of in-home workers and direct support professionals, as well as workforce and performance incentives for attendance and quality.

Missouri is interested in developing career paths to support education and training of direct support professionals. This would consist of creating certifications that direct support professionals could apply as credits to achieve further health professional opportunities. These efforts build upon the current registered apprenticeship efforts designed for direct support professionals.

New and/or Additional HCBS

Prior to the passage of ARP, Missouri began transforming its Nursing Facility Level of Care (LOC) criteria with a scheduled implementation date of July 30, 2021. After thorough analysis and research, the state expects the change in the criteria will result in a change to the population of those that meet LOC. Missouri's LOC Transformation creates a state system where vulnerable populations in need and at risk will now be able to access care in the least restrictive setting

where other participants that do not require hands-on care to maintain independence would no longer meet LOC. In order to demonstrate compliance with section 9817 of the ARP, Missouri will officially postpone the implementation of LOC Transformation from July 30, 2021 to October 31, 2021. In addition to the transformed LOC criteria, individuals will continue to be assessed with the existing LOC criteria. This means participants will be assessed for LOC eligibility under the transformed “new” LOC criteria and the existing “old” LOC criteria. Missouri will maintain this dual system until April 1, 2024 when the existing “old” LOC criteria will effectively sunset and the state will only consider eligibility under the “new” criteria. Missouri proposes to utilize enhanced HCBS FMAP earnings for the individuals who would gain eligibility to services because of this state policy change.

Missouri is also interested in increasing annual home modification spending limits in all applicable waivers. Providers have requested an increase to this limit and indicate the current limit is a barrier. This would serve as a trial opportunity to see if increased limits provide further access for modifications.

The state has also begun the process of re-initiating a PACE program and anticipates initial enrollment in this program to begin January 2022.

Missouri is exploring a medical day care model for medically fragile children to attend school or daycare. Facilities would have a medical wing or room staffed with the necessary nursing and therapy personnel. This would allow children the opportunity to learn and socialize but have needed medical care available.

Strengthening Assessment and Person-Centered Planning Practices

Missouri would expand our reassessment partnerships by providing targeted enhanced administrative rates for reassessments performed. Partners currently receive \$75 per reassessment, a rate last modified in 2014. This proposal would increase certain rates with an optional quality bonus payment for assessors that meet specified quality standards. The state has already implemented a quality review process staff to review a statistically valid sample of reassessments and this review would be extended to our partners under this plan.

The state is exploring opportunities to support the exchange of screening and assessment data across health information exchanges. This would build on the work of the Administration for Community Living to connect to the Cumulus platform.

Missouri is implementing the MO Health Risk Screen Tool (HRST). Funding would support the upfront one-time training costs of raters and other team members for the MO HRST Implementation process. Once all waiver participants have an initial HRST screen, the plan is to develop a specific Health & Welfare waiver performance measure to meet the associated waiver assurance regarding participant health and welfare.

Quality Improvement Activities

Missouri is interested in pursuing additional provider review services to enhance quality services. This initiative would include provider of service compliance reviews; annual provider performance reports; development of a provider scorecard; clinical mortality review; due process coordination; and other validation reviews, reports and technical assistance.

Funding could be used to enhance DD Medication Administration Certification in an effort to reduce medication errors identified through data.

The state has begun research and planning for value-based purchasing (VBP). Enhanced HCBS FMAP funds could be used for research and planning for additional health IT tools and capabilities to support population health management, data analysis, quality measures, and financial reconciliation for the VBP model.

Expanding Use of Technology and Telehealth and Employing Cross-System Data Integration Efforts

Missouri is interested in exploring the following technology initiatives:

- Ensure all claims have electronic visit and verification (EVV) data and check for program eligibility prior to payment. These checks would be done on the front end by processing and rejecting invalid claims before they get to the MMIS, eliminating pay and chase.
- Multiple systems spanning across executive agencies has been a long-standing barrier to effective care management and value-based payment for the HCBS population. DSDS would explore additional case management system options which would allow additional interoperability with other agencies.
- Enhance DD Case Management System by adding all non-waiver programs/services being administered. This enhancement would support an automated processing system for all DD supported individuals and increase care coordination.
- Implement one-time system enhancements to incorporate more interoperability in service planning and authorizations
- Develop Health Risk Screening (HRS) Interoperability with the Case Management Systems.
- Research and planning for additional health IT tools and capabilities to support population health management, data analysis, quality measure and financial reconciliation for VBP model.
- Through the LEAP Award, Missouri is testing the sharing of Individualized Service Plans/eLTSS data with supported employment providers. Funding could be utilized to support the State's online case management system in putting this into production.

- Develop HCBS Provider Interfaces with health information networks to support ADT alerts and query-based CCD/CCDA exchange.
- Award funding to HCBS providers to support provider IT system adoption.

Adopting Enhanced Care Coordination

While the Aged, Blind and Disabled populations represent the highest percentage of Medicaid spending, large portions of the population do not receive care coordination. Missouri would seek to build upon existing health care home models to identify HCBS participants with the highest Medicaid costs and provide care coordination in an effort to reduce unnecessary medical costs. Many stakeholders already provide this service to private health systems, and the service could be tailored to ensure collaboration with the HCBS provider. DSDS and DMH would coordinate with MO HealthNet to provide an analysis of the results to inform future investments.

Missouri could also develop Health Risk Screening (HRS) as part of the health care home design.

The state could offer time-limited incentive payments to providers to encourage participation in an ECHO, a collaborative effort between DMH, leading content experts, and providers with interest in developing expertise in supporting children with a dual developmental/intellectual and behavioral health diagnosis.

Missouri is also interested in enhancing case management and care coordination for children with special health care needs (Medicaid Healthy Children and Youth Program). The state would contract with a team of medical professionals providing regular outreach to families and direct referrals for additional services to avoid unnecessary hospitalizations.