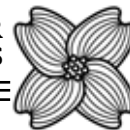




RULES OF
**Department of Health and Senior
Services**
**Division 15—Division of Senior and Disability
Services**
Chapter 8—Consumer-Directed Services

Title	Page
19 CSR 15-8.100 Definitions	3
19 CSR 15-8.200 Eligibility	3
19 CSR 15-8.300 Eligibility for Non-Medicaid Eligible Program	5
19 CSR 15-8.400 Vendors	5
19 CSR 15-8.500 Hearing Rights	8
19 CSR 15-8.510 Informal Review (Rescinded July 30, 2006)	9
19 CSR 15-8.520 Hearings (Rescinded July 30, 2006)	9



**TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR
SERVICES**

**Division 15 – Division of Senior and Disability
Services**

Chapter 8 – Consumer-Directed Services

19 CSR 15-8.100 Definitions

PURPOSE: This rule defines terms used in establishing procedures for the provision of consumer-directed services under the Department of Health and Senior Services to eligible consumers through eligible vendors, subject to legislative appropriations.

(1) As used in this rule and other rules established for consumer-directed services (CDS), except as otherwise required for the context, the following terms shall have the meanings ascribed:

(A) Adjusted gross income. The amount reported to the Internal Revenue Service (IRS) as adjusted gross income on the previous calendar year's income tax return for the consumer and the consumer's spouse;

(B) Assets. Any tangible, real, or personal property as would be reported to the Department of Social Services (DSS), Family Support Division (FSD) for the purpose of determining eligibility for Medicaid;

(C) Consumer. A physically disabled person determined by the Department of Health and Senior Services (DHSS) to be eligible to receive consumer-directed services (CDS). Consumer does not include any individual with a legal limitation of his or her ability to make decisions, including the appointment of a guardian or conservator, or who has an effective power of attorney that authorizes another person to act as the agent or on behalf of the individual for any of the duties required by the CDS program;

(D) Consumer-directed. The hiring, training, supervising, and directing of the personal care attendant (attendant) by the physically disabled person;

(E) Consumer-directed services (CDS). All services that are required or may be provided as part of the CDS program;

(F) Disability-related medical expenses. Any medical expense, as defined and approved by the IRS, that is directly related to the consumer's disability;

(G) Health care coverage. Any insurance policy that provides personal care assistance benefits;

(H) Income. Any income as would be reported to DSS/FSD for the purpose of determining eligibility for Medicaid;

(I) Live independently. To reside and perform routine tasks of daily living and activities of daily living and activities in the community in a noninstitutional or unsupervised residential setting;

(J) Non-Medicaid eligible (NME). Has been found by DSS/FSD not to be eligible to participate under guidelines established by the Medicaid state plan;

(K) Non-Medicaid eligible (NME) program. Financial assistance for CDS through eligible vendors for individuals who are NME consumers;

(L) Personal care assistance (PCA) services. Those routine tasks provided to meet the unmet needs required by a physically disabled person to enable him or her to live independently;

(M) Personal care attendant (attendant). A person, other than the consumer's spouse, who performs PCA services for a physically disabled person;

(N) Physically disabled. Loss of, or loss of use of, all or part of the neurological, muscular or skeletal functions of the body to the extent that person requires the assistance of another person to accomplish routine tasks;

(O) Routine tasks. Routine tasks and instrumental activities of daily living include, but are not limited to, the following:

1. Bowel and bladder elimination;
2. Dressing and undressing;
3. Moving into and out of bed;
4. Preparation and consumption of food and drink;
5. Bathing and grooming;
6. Shopping/transportation;

7. Maintenance and use of prostheses, aids, equipment and other similar devices; and/or

8. Ambulation, housekeeping, or other functions of daily living based on an independent living philosophy as specified in state law and regulation;

(P) Undue hardship. The result of a significantly difficult circumstance experienced by the disabled consumer that creates a situation of burden, risk or harm to the consumer. Undue hardship includes, but is not limited to, the following:

1. Loss of consumer's income;
2. Overall disintegration of the family;
3. Abuse and neglect;
4. Misuse of child labor; and/or
5. Presence of physical contraindication(s);

(Q) Unit of service. One unit equals fifteen (15) minutes;

(R) Unmet needs. Routine tasks and activities of daily living which cannot be reasonably met by members of the consumer's household or other current support systems without causing undue hardship; and

(S) Vendor. Any person, firm or corporation having a written agreement with DHSS to provide services, including monitoring and oversight of the attendant, orientation and training of the consumer, and fiscal conduit services necessary for delivery of CDS to physically disabled persons.

AUTHORITY: sections 208.900, 208.927 and 208.930, RSMo Supp. 2005. This rule originally filed as 5 CSR 90-7.010. Original rule filed Jan. 10, 1985, effective May 13, 1985. Amended: Filed Aug. 1, 1988, effective Nov. 25, 1988. Emergency amendment filed Aug. 31, 1992, effective Sept. 10, 1992, expired Jan. 9, 1993. Amended: Filed Aug. 31, 1992, effective April 8, 1993. Amended: Filed May 31, 1994, effective Dec. 30, 1994. Amended: Filed Oct. 31, 1996, effective June 30, 1997. Amended: Filed June 28, 2001, effective Jan. 30, 2002. Amended: Filed Sept. 12, 2003, effective April 30, 2004. Moved to 19 CSR 15-8.100, effective Aug. 29, 2005. Emergency amendment filed Dec. 15, 2005, effective Dec. 25, 2005, expired June 23, 2006. Amended: Filed Dec. 15, 2005, effective July 30, 2006.*

**Original authority: 208.900, RSMo 2005; 208.927, RSMo 2005; and 208.930, RSMo 2005.*

19 CSR 15-8.200 Eligibility

PURPOSE: This rule establishes the criteria and procedures for determining an applicant eligible to receive consumer-directed services and describes consumer's responsibilities for consumer-directed services.

(1) Subject to legislative appropriations, the Department of Health and Senior Services (DHSS) shall provide financial assistance for consumer-directed services (CDS) through eligible vendors to each consumer determined eligible to participate in the CDS program.

(A) All consumers must meet the following general criteria for eligibility under the CDS program:

1. Be at least eighteen (18) years of age;
2. Able to direct their own care (consumer-directed);



- 3. Capable of living independently with CDS;
- 4. Physically disabled;
- 5. Require at least a nursing facility level of care under regulations established by DHSS;
- 6. Unmet needs must be safely met at a cost that shall not exceed the average monthly Medicaid cost of nursing facility care as determined by the Department of Social Services (DSS);
- 7. Document proof of Medicaid eligibility under Title XIX of the Social Security Act pursuant to federal and state laws and regulations; and
- 8. Participate in an assessment and/or evaluation conducted by DHSS to assign point values pursuant to federal and state laws and regulations.

(2) Individuals eligible for Medicaid under Title XIX of the Social Security Act who do not meet the above criteria for the CDS program shall be referred to other programs or agencies, as appropriate, to determine eligibility for personal care services pursuant to federal and state laws and regulations.

(3) Any assessments and/or evaluations shall be conducted by DHSS or its designee, utilizing the approved interactive assessment tool.

(4) The CDS plan of care is based on the assessment and/or evaluation performed by DHSS and determines the appropriateness and adequacy of services and ensures that services furnished are consistent with the nature and severity of the individual's disability.

(A) The initial assessment and/or evaluation shall be conducted in the consumer's home or place of residence and include, but not be limited to, the following:

- 1. The functions of daily living;
- 2. The frequency and duration of the routine tasks or activity(ies) required to live independently; and
- 3. A description of met and/or unmet needs.

(B) The CDS plan of care shall include, but not be limited to, the following:

- 1. The maximum number of units of personal care assistance (PCA) to be provided based on the consumer's unmet needs;
- 2. The description and frequency of services to be provided as documented on the assessment and/or evaluation;
- 3. The starting date for PCA services;
- 4. The date for reassessment or reevaluation of CDS services;
- 5. Documentation of the consumer's choice of vendor; and
- 6. Consent signatures by the consumer and DHSS.

(C) Upon request, copies of the plan of care will be provided to the consumer.

(D) If a consumer is receiving services or transferring from another service provider or agency, DHSS is responsible for collaborating and coordinating services through the plan of care.

(5) The individual shall be notified of DHSS's decision regarding eligibility for CDS within ten (10) days of the date of the decision.

(6) CDS are consumer-directed and the consumer shall be responsible, at a minimum, for the following:

- (A) Selection, hiring, training, and supervision of the consumer's personal care attendant (attendant);
- (B) Expectation of the use of Electronic Visit Verification (EVV) in compliance with 13 CSR 70-3.320;
- (C) Ensuring that units submitted for reimbursement do not

exceed the amounts authorized by the CDS plan of care and/or those eligible for reimbursement through Medicaid;

(D) Promptly notifying DHSS and/or the vendor within ten (10) days of any changes in circumstances affecting the CDS plan of care and/or changes in the consumer's place of residence;

(E) Prompt notification to the vendor regarding any problems resulting from the quality of services rendered by the attendant. Any problems not resolved with assistance from the vendor shall be reported to DHSS;

(F) Allowing the vendor to comply with its quality assurance supervision process, which shall include but not be limited to annual face-to-face home visits and monthly case management activities; and

(G) Report to DHSS significant changes in consumer's health and ability to self-direct care by contacting the vendor and/or DHSS.

(7) The needs of the consumer shall be reassessed and/or reevaluated at least annually by DHSS, and the amount of assistance authorized by DHSS shall be maintained, adjusted, or eliminated accordingly.

(8) A consumer's CDS may be discontinued or denied by DHSS in certain circumstances including but not limited to the following:

(A) DHSS and/or the vendor learns of circumstances that require the denial or closure of a consumer's case, including but not limited to, death, admission to a long-term care facility, consumer no longer needing services, and/or the inability of the consumer to self-direct his or her services;

(B) The consumer has falsified records, committed fraud, or provided DHSS with false information about his or her condition(s), functional capacity, or level of care during the assessment that resulted in an authorization of services not needed;

(C) The consumer is noncompliant with the plan of care. Noncompliance requires persistent actions by the consumer or his or her family/representative which negate the services provided in the plan of care;

(D) The consumer or a member of the consumer's household threatens and/or abuses the attendant and/or vendor to the point where the staff's welfare is in jeopardy;

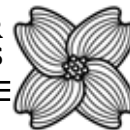
(E) The consumer's needs exceed available plan of care hours; and/or

(F) The attendant is not providing services as set forth in the CDS plan of care and attempts to remedy the situation have been unsuccessful.

(9) DHSS shall notify the consumer/applicant in writing regarding denial, reduction, or termination of CDS services.

(10) The consumer may request a hearing under the rules promulgated by DHSS. DHSS shall not suspend, reduce or terminate services provided to a consumer during this time period, unless the consumer requests in writing that services be suspended, reduced or terminated.

AUTHORITY: sections 208.903, 208.906, 208.921, and 208.927, RSMo 2016, and sections 208.909, 208.924, and 208.935, RSMo Supp. 2023. This rule originally filed as 5 CSR 90-7.100. Original rule filed June 28, 2001, effective Jan. 30, 2002. Amended: Filed Sept. 12, 2003, effective April 30, 2004. Moved to 19 CSR 15-8.200, effective Aug. 29, 2005. Emergency amendment filed Dec. 15, 2005, effective Dec. 25, 2005, expired June 23, 2006. Amended: Filed Dec. 15, 2005, effective July 30, 2006. ** Amended: Filed Sept. 1, 2023, effective Feb. 29, 2024.*



**Original authority: 208.903, RSMo 2005; 208.906, RSMo 2005; 208.909, RSMo 2005; 208.921, RSMo 2005; 208.924, RSMo 2005; 208.927, RSMo 2005; and 208.935, RSMo 2020.*

***Pursuant to Executive Order 21-09, 19 CSR 15-8.200 was suspended from April 3, 2020 through December 31, 2021.*

19 CSR 15-8.300 Eligibility for Non-Medicaid Eligible Program

PURPOSE: This rule incorporates changes to the non-Medicaid eligible consumer-directed services program required by Senate Bill 74/49, 93rd General Assembly, First Regular Session (2005), to establish the criteria and procedures for determining eligibility for consumer-directed services through the non-Medicaid eligible program.

(1) Subject to legislative appropriations, the Department of Health and Senior Services (DHSS) shall provide financial assistance for consumer-directed services (CDS) through eligible vendors, pursuant to applicable state law and regulation, to each person determined eligible to participate in the non-Medicaid eligible (NME) program. All consumers must meet the CDS requirements found in state law and regulations, except for proof of Medicaid eligibility under Title XIX of the Social Security Act. In addition, consumers must meet the following criteria for eligibility under the NME program:

(A) Participation in the NME program through the Department of Elementary and Secondary Education, Division of Vocational Rehabilitation, on June 30, 2005, and make application to DHSS;

(B) Demonstrate financial need and eligibility pursuant to the applicable rules and regulations;

(C) Provide proof of having been found by the Department of Social Services (DSS) ineligible to participate in the Medicaid state plan; and

(D) Does not have access to employer-sponsored or other health care coverage that includes personal care assistance, or the costs of such coverage exceed on a monthly basis one hundred thirty-three percent (133%) of the monthly average premium required in the state's current Missouri Consolidated Health Care Plan (MCHCP).

(2) Financial need and eligibility are based upon the adjusted gross income (AGI) of the applicant and the applicant's spouse and the assets of the applicant and/or the applicant's spouse.

(A) In order to demonstrate a financial need, an applicant and the applicant's spouse must have an AGI, less disability-related medical expenses as approved by DHSS, that is equal to or less than three hundred percent (300%) of the federal poverty level.

1. AGI is calculated on an annual basis by calendar year, using the AGI as reported to the Internal Revenue Service, less any disability-related medical expenses paid during the same year.

2. Disability-related medical expenses must be documented and proof of payment is required.

(B) Applicant and/or the applicant's spouse shall not have assets in excess of two hundred fifty thousand dollars (\$250,000).

1. Any assets of the applicant and/or the applicant's spouse transferred within twelve (12) months of the date of application shall be included in the calculation of assets.

(3) Consumers shall pay a monthly premium to DHSS.

(A) The premium shall be equal to the statewide average premium required for the MCHCP, but shall not exceed five percent (5%) of the consumer's and the consumer's spouse's AGI for the previous calendar year.

(B) Nonpayment of the required premium shall result in denial or termination of services, unless the person demonstrates good cause for such nonpayment by providing documentation of income and expenses that substantiates the inability to pay the premium.

1. Any consumer who is denied services for nonpayment of the premium shall not receive services until past due and current premiums are paid.

2. Any consumer who does not make any payments for past due premiums for sixty (60) consecutive days shall have their enrollment in the program terminated.

3. Any consumer who is terminated due to non-payment of premiums shall not be re-enrolled unless all past due and current premiums are paid prior to re-enrollment.

4. Nonpayment shall include payment with a returned, refused, or dishonored instrument.

(4) Continued participation in the NME program shall require that eligibility be reevaluated on an annual basis, pursuant to applicable state law and regulation.

(A) The amount of financial assistance shall be adjusted or eliminated based on the outcome of the reevaluation and shall be recorded in the consumer's plan of care.

(B) Consumers must respond and provide requested documentation within ten (10) days of DHSS' notice of reevaluation of eligibility.

(C) Failure by the consumer to provide requested documentation within ten (10) days will result in DHSS sending the consumer a notification letter that he or she has ten (10) days to file an appeal or services will be terminated.

(5) Applicants or consumers whose services are denied, reduced, or terminated have the right to request a hearing under the applicable rules of DHSS.

AUTHORITY: section 208.930, RSMo Supp. 2005. Emergency rule filed Dec. 15, 2005, effective Dec. 25, 2005, expired June 23, 2006. Original rule filed Dec. 15, 2005, effective July 30, 2006.*

**Original authority: 209.930, RSMo 2005.*

19 CSR 15-8.400 Vendors

PURPOSE: This rule establishes the criteria, procedures, and responsibilities for entities eligible to be vendors of consumer-director services administered by the Department of Health and Senior Services.

(1) All vendors of the consumer-directed services (CDS) program shall –

(A) Have a philosophy that promotes the consumer's ability to live independently in the most integrated setting. This philosophy includes the following independent living services:

1. Advocacy;
2. Independent living skills training;
3. Peer counseling; and
4. Information and referral;

(B) Have a valid written agreement with the Missouri Medicaid and Compliance (MMAC);

(C) Have a valid Medicaid participation agreement pursuant



to federal and state laws and regulations;

(D) Designate to MMAC the manager who will be responsible for the vendor’s day-to-day operation. This manager shall be a policy maker and supervise the vendor’s record keeping, service delivery verification, training, and orientation of consumers in skills needed to recruit, employ, instruct, supervise, and maintain the services of attendants; and

(E) Implement a quality assurance and supervision process that ensures program compliance and accuracy of records, including but not limited to –

1. CDS managers shall be required to successfully complete (or have completed) the CDS certified manager orientation and test offered (quarterly or as needed) by MMAC at no charge. Completion of the test for all new managers is required within six (6) months of hire;

2. CDS managers shall annually attend MMAC-sponsored training update CDS meeting; and

3. CDS vendors and managers shall maintain documentation of attendance for all training, testing, and meetings.

(2) Vendors shall have a written pandemic preparedness policy to be followed when service delivery must be interrupted due to a pandemic. Vendors shall distribute this policy to all consumers annually. Vendors shall train all consumers on this policy at least annually. Consumers shall train attendants on this policy at least annually.

(3) Vendors shall perform, directly or by contract, payroll and fringe benefit accounting functions for consumers, including but not limited to –

(A) Collecting Electronic Visit Verification (EVV) records and verifying accuracy;

(B) Transmitting individual payments to the personal care attendant (attendant) on behalf of the consumer; and

(C) Ensuring all payroll, employment, and other taxes are paid timely.

1. The vendor shall be liable to the consumer for any garnishment action occurring as a result of the vendor’s failure to timely pay payroll, employment, or other taxes on behalf of the consumer.

2. The vendor shall notify the consumer of any communications or correspondence from any federal, state, or local tax authority of any overdue or unpaid tax obligation, as well as any notice of an impending garnishment.

3. The vendor may be subject to a one thousand dollar (\$1,000) penalty per occurrence of the vendor’s failure to timely pay payroll, employment, or other taxes on behalf of the consumer.

(4) Vendors shall, directly or by contract, file claims for Medicaid reimbursement.

(5) In addition to the above requirements, vendors shall be responsible, directly or by contract, for the following:

(A) Maintaining a list of eligible attendants –

1. Ensuring that each attendant is registered, screened, and employable pursuant to the Family Care Safety Registry (FCSR) and the Employee Disqualification List (EDL) maintained by Department of Health and Senior Services (DHSS) and applicable state laws and regulations prior to beginning service delivery;

2. Notifying the attendant of his or her responsibility to comply with applicable state laws and regulations regarding reports of abuse or neglect;

3. Attendants must meet the following qualifications:

A. Be at least eighteen (18) years of age;

B. Be able to meet the physical and mental demands required to perform specific tasks required by a particular consumer;

C. Agree to maintain confidentiality;

D. Be emotionally mature and dependable;

E. Be able to handle emergency type situations;

F. Be a person other than the consumer’s spouse or guardian;

G. Not be a consumer; and

H. Have not been involved in Medicaid fraud previously; and

4. The attendant is an employee of the consumer only for the time period subsidized with CDS funds, but is never the employee of the vendor, DHSS, or the state of Missouri;

(B) Training and orientation of consumers in the skills needed to recruit, employ, instruct, supervise, and maintain the services of attendants including but not limited to –

1. Assisting consumers in the general orientation of attendants as requested by the consumer. To the fullest extent possible, this shall take place in the presence of the attendant;

2. Federal and state requirements regarding the mandatory use of EVV;

3. Identification of issues that would be considered fraud of the program;

4. Allowable and non-allowable tasks;

5. Notifying consumers that falsification of any attendant visit verification records shall be considered fraud and shall be reported to MMAC;

6. Rights and responsibilities of the attendant;

7. Identification of abuse, neglect, and/or exploitation; and

8. The attendant shall report to DHSS and/or the vendor if he or she witnesses significant deterioration of the health of the consumer or if he or she has a belief that the consumer is no longer capable of self-directed care. Failure of the attendant to report this information should be reported by the vendor to DHSS.

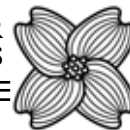
(C) Processing of consumers’ and/or attendants’ inquiries and problems;

(D) Public information, outreach, and education activities to ensure that persons with disabilities are informed of the services available and have maximum opportunity for participation;

(E) Maintaining confidentiality of consumer records, including eligibility information from DHSS, pursuant to applicable federal and state laws and regulations;

(F) The vendor shall perform ongoing monitoring of the provision of services in the plan of care and shall assess the quality of care being delivered. Such monitoring shall include –

1. At least one (1) annual face-to-face visit as outlined in section 208.918, RSMo. Face-to-face is defined as an interaction that occurs in person and does not include interactions that occur through telecommunication or electronic technologies. Face-to-face visits shall be completed within three hundred sixty-five (365) days from original authorized care plan, and annually thereafter. Documentation of each face-to-face visit must contain at a minimum, the name of the monitoring individual, those present at the time of the visit, service delivery evaluation summary, the quality of care being delivered, and date and time of the visit. All documentation must be maintained in the consumer’s case file and shall be available to send to DHSS upon request. The vendor shall report to DHSS if services are not being provided to the consumer as authorized in the plan of care, which may result in suspension of services



to the consumer;

2. Monthly case management activities which must be completed by phone, videoconference, or in-person with the consumer;

3. Other monitoring may include electronic monitoring, telephone checks, written case notes, or other department-approved methods. The ongoing monitoring shall not preclude the vendor's responsibility of ongoing diligence of case management activity oversight;

(G) Ensuring the consumer has an emergency and/or backup plan;

(H) Ensuring that the consumer's case file contains, at a minimum, the following:

1. Employer Identification Number and Missouri Tax ID;

2. Written plan of care and service authorization that document the type of services and quantity of units to be provided;

3. Documentation of use of EVV in accordance with 13 CSR 70-3.320;

4. Copies of all correspondence with DHSS, the consumer's physician, other service providers, and other administrative agencies;

5. Documentation of training provided to the consumer in the skills needed to understand and perform the essential functions of an employer;

6. Documentation of the consumer's emergency and/or backup plans;

7. Signed documentation that the consumer has been informed of their rights concerning hearings and consumer responsibilities.

A. Such forms must comply with Medicaid and/or DHSS' requirements; and

8. Any pertinent documentation regarding the consumer;

(I) Demonstrating positive impact on consumer outcomes regarding the provision of CDS through the submission of quarterly service reports and an annual service report to MMAC;

(J) Operating programs, services, and/or activities in such a manner as to be readily accessible to and usable by persons with disabilities;

(K) Providing information necessary to conduct state and/or federal audits, as requested by MMAC;

(L) Complying with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, and the Age Discrimination Act of 1975;

(M) Complying with applicable statutes and regulations regarding reports of abuse or neglect; and

(N) Complying with applicable statutes and regulations regarding reports of misappropriation of a consumer's property or funds or the falsification of documents verifying CDS delivery.

(6) Vendors shall refer the following situations upon discovery to DHSS for investigation:

(A) Circumstances that may require closure or termination of services, including but not limited to –

1. Death;

2. Admission into a long-term care facility;

3. The consumer no longer needing services;

4. The inability of the consumer to self-direct and/or significant changes which would result in the need of a change in the authorized care plan for the consumer; and/or

5. An inability to continue to meet the maintenance needs of the consumer because the plan of care hours needed

to ensure the health and safety of the consumer exceed availability;

(B) Upon a finding that such circumstances exist, DHSS may close or terminate services.

(7) Vendors, after notice to DHSS –

(A) May suspend services to consumers in the following circumstances:

1. The inability of the consumer to self-direct;

2. Falsification of records, falsification of condition, or fraud;

3. Persistent actions by the consumer of noncompliance with the plan of care;

4. The consumer or a member of the consumer's household threatens or abuses the attendant and/or vendor; and/or

5. The attendant is not providing services as set forth in the plan of care and attempts to remedy the situation have been unsuccessful; and

(B) Shall provide written notice to DHSS and the consumer listing specific reasons for requesting closure or termination. All supporting documentation shall be maintained in the consumer's case file. DHSS shall investigate the circumstances reported by the vendor and assist the consumer in accessing appropriate care. Upon a finding that such circumstances exist, DHSS may close or terminate services.

(8) Vendors shall comply, either directly or by contract, with the following fiscal requirements:

(A) No state or federal funds shall be authorized or expended to pay for CDS if the primary benefit of such services is to the household unit, or is a task that members of the consumer's household may reasonably be expected to share or do for one another, unless such service is above and beyond typical activities household members may reasonably provide for another household member without a disability;

(B) No state or federal funds shall be authorized or expended to pay for CDS provided by an attendant who is listed on any of the background check lists in the Family Care Safety Registry, pursuant to applicable state laws and regulations, unless a good cause waiver is first obtained from DHSS in accordance with applicable state laws and regulations;

(C) No state or federal funds shall be authorized or expended to pay for personal care assistance services if any direct employee of the CDS vendor conducts the face-to-face home visit of a consumer for whom such employee is also the attendant, unless such person provides services solely on a temporary basis on no more than three (3) days in a thirty- (30-) day period. The certified manager shall maintain records and provide to MMAC upon request.

(D) The general assembly shall set the statewide reimbursement rate to be paid for CDS;

(E) The total monthly payment for CDS made on behalf of a consumer shall not exceed one hundred percent (100%) of the average statewide monthly cost for care in a nursing facility as defined in applicable state laws and regulations;

(F) Assure that federal funds shall not be used to replace funds from nonfederal sources and that the vendor shall continue or initiate efforts to obtain support from private sources or other public organizations;

(G) Be responsible for repayment of any federal or state funds that are deferred and/or ultimately disallowed;

(H) CDS Quarterly Financial and Service Reports shall be submitted to MMAC thirty (30) days after the end of each calendar quarter;

(I) Maintain CDS financial records separately from any other



financial records and make all consumer and CDS financial records, documents, reports, and data available to MMAC upon request; and

(J) Submit an annual audit or review by a properly licensed independent practitioner (certified public accountant licensed in the state of Missouri) pursuant to applicable federal and state laws and regulations, including any audit parameters as established by DHSS.

1. Audit requirements for vendors –

A. An annual financial statement audit is required if the vendor's annual gross revenue is two hundred thousand dollars (\$200,000) or more.

B. An annual financial statement audit or annual financial statement review is required if the vendor's annual gross revenue is less than two hundred thousand dollars (\$200,000).

2. The audit report must be submitted to MMAC within one hundred fifty (150) days after the end of the vendor's fiscal year.

(9) MMAC may withhold funding if the vendor does not submit required documentation pursuant to this rule.

(10) The vendor shall maintain, at a minimum, all case files and records of its activities pursuant to applicable state laws and regulations in a central location for six (6) years. Records must be provided to DHSS or its designee upon request and must be maintained in a manner that will ensure they are readily available for monitoring or inspection. Such records shall include but not be limited to records verifying the delivery of services.

(11) MMAC or its designee shall conduct on-site visits, which may be announced or unannounced, for the purpose of program and/or fiscal monitoring of the vendor. The vendor shall provide proof of maintaining a business location that shall comply with any and all applicable city, county, state, and federal requirements upon request of MMAC. The vendor's principal place of business shall have staff on the premises with access to records during business hours as prescribed by the vendor's written agreement with MMAC.

(12) MMAC may invoke sanctions, upon written notice to the vendor, when it has cause to do so, including but not limited to the following:

(A) Elimination of one (1) or more counties from the vendor's authorized service commitment area and the subsequent transfer of consumers served in those counties to other vendors;

(B) Prospective cessation, temporarily or permanently, of new consumer service authorizations to the vendor, either for specific counties or for all counties served by the vendor;

(C) Demand that the vendor make certain assurances, including but not limited to audits or financial assurances to satisfy MMAC; and/or

(D) Any remedies calculated to correct or prevent further impairment of the delivery of service by the vendor or the attendant that is substandard, delivered in a substandard manner, or delivered but not documented according to the requirements of this rule.

(13) MMAC may take immediate action to protect consumers from vendors who are found to be out of compliance with this rule and/or any other statute and/or rule applicable to the CDS program, when such noncompliance creates a risk of injury or harm to the consumer.

(14) MMAC may suspend or terminate the written agreement of any vendor found to be out of compliance with the written agreement and with the provisions of this rule and/or the requirements of applicable state laws and regulations.

AUTHORITY: sections 208.900, 208.903, 208.906, 208.912, 208.915, 208.921, and 208.927, RSMo 2016, and sections 208.909, 208.918, and 208.930, RSMo Supp. 2023. This rule originally filed as 5 CSR 90-7.200. Original rule filed June 28, 2001, effective Jan. 30, 2002. Amended: Filed Sept. 12, 2003, effective April 30, 2004. Moved to 19 CSR 15-8.400, effective Aug. 29, 2005. Emergency rescission and rule filed Dec. 15, 2005, effective Dec. 25, 2005, expired June 23, 2006. Rescinded and readopted: Filed Dec. 15, 2005, effective July 30, 2006. ** Amended: Filed Sept. 1, 2023, effective Feb. 29, 2024.*

**Original authority: 208.900, RSMo 2005; 208.903, RSMo 2005; 208.906, RSMo 2005; 208.909, RSMo 2005; 208.912, RSMo 2005; 208.915, RSMo 2005; 208.918, RSMo 2005; 208.921, RSMo 2005; 208.927, RSMo 2005; and 208.930, RSMo 2005.*

***Pursuant to Executive Order 21-07, 19 CSR 15-8.400, subsection (7)(f) was suspended from May 18, 2020 through August 31, 2021. Pursuant to Executive Order 21-09, 19 CSR 15-8.400, paragraph (4)(A), subsections (4)(B), (6)(B), and (7)(B), and section 208.918.1(2) was suspended from April 30, 2020 through December 31, 2021.*

19 CSR 15-8.500 Hearing Rights

PURPOSE: This rule establishes procedures by which an applicant or consumer dissatisfied with a determination made regarding the provision of services by the Department of Health and Senior Services (DHSS) can request a hearing.

(1) When an applicant or consumer is determined ineligible for consumer-directed services (CDS) or when a dispute arises concerning the provision of CDS, after preparation of the CDS plan (plan of care), or termination of CDS, the applicant or consumer may request, in writing, a hearing with the Department of Social Services (DSS).

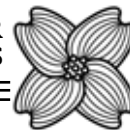
(2) An applicant or consumer may request a hearing by contacting Department of Health and Senior Services (DHSS) in writing within ninety (90) days of denial of eligibility, denial of financial assistance, the determination of financial assistance, discontinuation, suspension or reduction of CDS.

(3) If the consumer appeals in writing within ten (10) days of the mailing of the notice regarding denial, suspension, reduction or termination of CDS, DHSS will not suspend, reduce, or terminate services provided to a consumer under an existing plan of care pending a decision from a hearing, unless the consumer requests in writing that services be suspended, reduced or terminated.

(A) The consumer shall be responsible for repayment of any federal or state funds expended for services while the appeal is pending, when if DHSS' decision is upheld and the state requests repayment of such funds.

AUTHORITY: sections 208.921, 208.927 and 208.930, RSMo Supp. 2005. This rule originally filed as 5 CSR 90-7.300. Original rule filed June 28, 2001, effective Jan. 30, 2002. Moved to 19 CSR 15-8.500, effective Aug. 29, 2005. Emergency amendment filed Dec. 15, 2005, effective Dec. 25, 2005, Expired June 23, 2006. Amended: Filed Dec. 15, 2005, effective July 30, 2006.*

**Original authority: 208.921, RSMo 2005; 208.927, RSMo 2005; and 208.930, RSMo 2005.*



19 CSR 15-8.510 Informal Review

(Rescinded: July 30, 2006)

AUTHORITY: sections 161.092, 178.671 and 178.673, RSMo 2000. This rule originally filed as 5 CSR 90-7.310. Original rule filed June 28, 2001, effective Jan. 30, 2002. Moved to 19 CSR 15-8.510, effective Aug. 29, 2005. Emergency rescission filed Dec. 15, 2005, effective Dec. 25, 2005, expired June 23, 2006. Rescinded: Filed Dec. 15, 2005, effective July 30, 2006.

19 CSR 15-8.520 Hearings

(Rescinded: July 30, 2006)

AUTHORITY: sections 161.092, RSMo Supp. 2003 and 178.671 and 178.673, RSMo 2000. This rule originally filed as 5 CSR 90-7.320. Original rule filed June 28, 2001, effective Jan. 30, 2002. Amended: Filed Sept. 12, 2003, effective April 30, 2004. Moved to 19 CSR 15-8.520, effective Aug. 29, 2005. Emergency rescission filed Dec. 15, 2005, effective Dec. 25, 2005, expired June 23, 2006. Rescinded: Filed Dec. 15, 2005, effective July 30, 2006.