As appropriate, current and potential participants of Home and Community Based Services (HCBS) authorized by the Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS) shall have written notification through an Adverse Action Notice (HCBS-12) of any agency action that adversely affects the request for, or amount of, authorized HCBS. In addition, the HCBS provider shall receive verbal notification of the adverse action. These agency actions include, but are not limited to, any change (i.e. decrease or closing of an HCBS), denial of a request for change (i.e. increase or an additional HCBS), or denial of an initial request for HCBS. Current or potential participants shall inform DSDS of their intent to appeal, either verbally or in writing, the proposed adverse action as a result of the determination by DSDS.

- When a participant is in agreement with or requests a reduction, denial, or closing of HCBS, this is not considered an adverse action and thus does not require the mailing of an HCBS-12. This must be thoroughly documented in the participant’s case record in the HCBS Web Tool.

Adverse action as a result of ineligibility for Medicaid HCBS benefits authorized by DSDS is subject to appeal initiated through the Department of Social Services (DSS), Family Support Division (FSD). This includes participants who become enrolled in a Medicaid managed care plan.

- In such cases, the participant shall be notified by completing the Notice of Closure for Home and Community Based Services (HCBS-12m) form (see Appendix 6);
- The HCBS-12m shall be mailed within one (1) business day of receipt of information of ineligibility. This action does not require a ten (10) business day waiting period.

The participant has ninety (90) business days from the date the HCBS-12 is mailed to appeal the decision.

- However, if the participant wants to continue receiving current services, they must appeal within ten (10) business days of the date the HCBS-12 was mailed.

**NOTE:** If the appeal is ruled in favor of DSDS, the participant and/or the participant’s estate may be liable for the cost of HCBS delivered during the appeal process. The participant shall be notified of the possible liability.

- The participant’s decision to continue or discontinue HCBS shall be communicated to the provider and thoroughly documented in the participant’s case record in the HCBS Web Tool.

Participants placed on the Independent Living Waiver (ILW) Waiting List (see Policy 3.55) have the right to appeal their number on the list.

- These participants shall be notified by sending the Waiting List Notice for ILW Services (HCBS-12w). This action does not require a ten (10) business day waiting period.
- The participant has ninety (90) business days from the date the HCBS-12w is mailed to appeal.
Within three (3) business days of an identified need for adverse action, DSDS shall mail an HCBS-12 explaining all the services affected and reason(s) for the adverse action, including the legal reference for the action to be taken (Appendix 1).

- For persons placed on the ILW Waiting List, the HCBS-12w shall be used to notify the participant.

Anyone may make the initial request for a hearing on the participant’s behalf. However, the participant must be contacted directly to confirm the request. If DSDS staff cannot reach the participant by the third attempt (see Policy 6.00), the hearing request shall not be processed and the adverse action will proceed as appropriate.

When the participant contacts DSDS verbally or in writing to request a hearing, DSDS shall complete the Application for State Hearing (HCBS-12a) with information provided by the participant (see Policy 6.00).

- If participant requests paperwork be sent to an authorized representative for the hearing process, he/she must complete and return an Authorization for Disclosure of Consumer Medical/Health Information form (see Policy 9.00, Appendix 6).

All forms and documents related to the adverse action process shall be uploaded to the participant’s case record in the HCBS Web Tool.

Pursuant to the Code of Federal Regulations (CFR), specifically 42 CFR 431.211 regarding advance notice of an adverse action, unless otherwise specified, any adverse action that results in a change to the case status or changes a prior authorization shall require a ten (10) business day notification prior to the date of the change or closing.

- The ten (10) business day period begins the day after mailing the HCBS-12 and ends the morning of the eleventh (11) business day.

When a participant contacts DSDS staff in response to an HCBS-12 or HCBS-12w, staff may need to make adjustments to the participant’s proposed care plan based on new information provided.

- A new HCBS-12 may be required in situations including, but not limited to:
  - When the proposed amount of current HCBS is increased, but not to the level requested by the participant;
  - If additional HCBS are denied; or
  - If the proposed care plan is further decreased.

- In these cases, DSDS shall mail a Reversal of Adverse Action (HCBS-12b) (Appendix 5) for the original action.

Exceptions to the ten day notification:
DSDS shall mail the HCBS-12 to the last known address in the following situations, without having to wait ten (10) days before processing the action, when:

- The participant does not meet Level of Care (LOC) during initial PreScreen or Initial Assessment;
- The participant is admitted to an institution where HCBS may not be continued;
- The participant has moved to another state and is no longer eligible to receive Medicaid benefits in Missouri; and
- The whereabouts of the participant is unknown (e.g., mail returned by Post Office indicates no known forwarding address).

NOTE: An HCBS-12 does not need to be mailed to the last known address if factual notification of the participant’s death is received.

PreScreen Level of Care Ineligibility

For initial requests for HCBS, an HCBS-12 shall be sent when a potential participant does not meet the minimum required level of care (LOC) score for the provision of HCBS.

Consumer Directed Services (CDS) / Independent Living Waiver (ILW) Participant Fraud

When the Special Investigations Unit (SIU) identifies evidence during an investigation to indicate that a CDS/ILW participant has been complicit in fraudulent activities, the SIU investigator will submit an SIU Referral Form to the appropriate Regional Evaluation Team (REV) email address. In the SIU Referral Form, the SIU investigator shall provide a case summary to the REV Team documenting evidence that the participant was complicit in the fraud and shall check the first box on the form. Once HCBS staff receives the referral, they shall upload the SIU Referral Form into the participant’s case record in the HCBS Web Tool.

Regional staff shall notify the participant of the closure of CDS/ILW services due to fraudulent activity. Staff shall follow the Adverse Action guidelines within this policy.

When the participant is in agreement with, or does not appeal, the closing of CDS/ILW, staff shall:

- Check the ‘CDS Restricted’ box in HCBS Web Tool;
  - This box will remain checked indefinitely.
- Document actions taken in the participant’s case record in the HCBS Web Tool;
- Close the associated CDS/ILW prior authorization lines in the HCBS Web Tool; and
- Review with the participant and authorize as appropriate other HCBS options to meet their care needs or close the case line in the HCBS Web Tool.
5.00
ADVERSE ACTIONS

When the participant appeals the decision to close CDS/ILW, see Policy 6.00 for specific guidelines.

- CDS/ILW services may be continued pending the hearing if so requested by the participant.

Regional staff may receive information directly from a participant or vendor that a participant has admitted to being complicit in CDS/ILW fraud. In these circumstances, Regional staff shall follow appropriate policy to make a report in Case Compass, and consult with the assigned SIU investigator to determine if an Adverse Action for CDS/ILW services should be processed immediately or following the investigation.

When the SIU identifies evidence during an investigation that supports the allegation the attendant committed fraud, but there is no proof that the participant was complicit in committing the fraud, e.g. signed false timesheets due to confusion or other reasons, the SIU investigator may:

- Submit an SIU Referral Form to the appropriate REV Team email address with the appropriate box checked regarding the recommendation that the participant be reassessed/reevaluated to determine the participant’s current capacity to direct their own care. Once HCBS staff receives the referral, they shall upload it into HCBS Web Tool.

Regional HCBS staff shall follow up with the participant to determine continued eligibility for CDS/ILW and take appropriate action based on the needs of the participant, which may include closing the CDS/ILW, authorizing other HCBS to meet their care needs, and/or adverse action.

For participants who do not request a hearing:

All affected HCBS shall be reduced or closed as appropriate. DSDS shall complete necessary actions for the reduction (see Policy 10.10) or discontinuation (see Policy 10.20).

- DSDS shall notify the HCBS provider of the action taken.
- DSDS shall document actions taken in the participant’s case record in the HCBS Web Tool.
- No further action is necessary for participants placed on the ILW Waiting List.

Certain case actions that do not affect eligibility for services are not considered an adverse action. These include, but are not limited to:

- Transfer from one HCBS provider to another HCBS provider, with no break in service; or,
- When no HCBS provider is available to serve the participant and it results in a loss of or break in services, the participant remains eligible for services and the case remains open pending availability of a HCBS provider.
Until an HCBS provider becomes available, DSDS shall enter ‘Assessment – State Designee’ in the Care Plan Services tab of the Assessment Screen in the HCBS Web Tool.

- The effective date shall be the first day of the last full month within 365 days from the last level of care determination.
- The end date shall be the last day of the last full month within 365 days from the last level of care determination.
- This authorization shall be approved and submitted on the Prior Authorization Screens.

Participants unable to find an available provider at the next annual reassessment shall have their case closed through the Adverse Action process.