The Division of Senior and Disability Services (DSDS) authorizes Home and Community Based Services (HCBS) to providers on behalf of eligible participants. HCBS providers must meet certain regulatory and contractual requirements to become and remain a Medicaid enrolled provider. When DSDS becomes aware of significant complaints regarding an HCBS provider, DSDS shall complete the Provider Complaint Report to document and report the complaint. Complaints may be made concerning any type of HCBS provider or their employees or attendants providing Consumer-Directed Services (CDS).

HCBS provider complaints generally fall into the following categories:

**Contract Issues** (for all HCBS providers) include:

- Failure of the provider to pay required taxes;
- Failure of the provider to maintain business or emergency contact numbers;
- Provider staff being unavailable for contact; and/or
- Noncompliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).
  - HIPAA violations include sharing any information about a participant with any other person/entity that does not have a need to know, e.g. bringing other persons to the participant’s home, sharing pictures of the participant, talking to other participants about participant’s private information, etc.
  - Potential HIPAA violations should first be reported to the HCBS provider’s Privacy Officer. If that does not resolve the problem, the violation shall also be reported to the Department of Social Services (DSS) Privacy Officer by calling 573-526-0413.

**Ethics Complaints** include:

- **Inappropriate conduct (all HCBS providers):**
  - Committing any act of abuse, neglect, or exploitation (ANE).
- **Inappropriate conduct (agency model only):**
  - Using participant’s car;
  - Consuming participant’s food or drink (except water);
  - Smoking in participant’s home;
  - Using participant’s telephone for personal calls;
  - Being at participant’s home when participant is not present;
  - Bringing other persons to participant’s home;
  - Discussing personal problems, religious or political beliefs with participant;
  - Consuming alcoholic beverages while in the participant’s home;
  - Consuming medicine for reasons other than prescribed while in the participant’s home;
  - Consuming drugs while in the participant’s home; and/or
PROVIDER COMPLAINT PROCESS

- Being impaired due to the consumption of alcohol, medication or drugs prior to service delivery.

- **Financial violations (all HCBS providers):**
  - Timesheet or billing fraud;

- **Financial violations (agency model only):**
  - Accepting gifts or tips;
  - Soliciting or accepting money or goods from participant for personal gain;
  - Purchasing any item from participant even at fair market value;
  - Assuming control of the participant or his/her estate, including power of attorney, conservatorship, or guardianship;
  - Adding names to bank accounts, deeds, titles, or any other documents regarding participant’s property; and/or
  - Taking anything from participant or his/her home.

**Regulatory Issues** include:

- For all HCBS providers -
  - Family Care Safety Registry (FCSR) / Employee Disqualification List (EDL) requirements;
  - Electronic Visit Verification (EVV) requirements;
  - Participant choice of provider;
  - Cooperating and communicating with state agency;
  - Providing services as authorized;
  - Providing services within required timeframes;
  - Providing adequate services;
  - Providing adequate training;
  - Maintaining adequate records;
  - Providing services not authorized on the official care plan;
  - Making mandatory reports to the Adult Abuse Hotline;

- For agency model only –
  - Keeping a qualified designated manager on staff;
  - Keeping a qualified Registered Nurse (RN) on staff;
  - Providing services to immediate family members;
  - Preventing unqualified personnel from providing services;
  - Providing transportation of participants; and/or
  - Obtaining physician’s orders, when necessary.
Any complaint or concern that does not appear to fit within the allegations listed above may be coded as ‘Other’ in Case Compass, with an explanation of the circumstances involved.

Some complaints are not appropriate for DSDS to accept and should be referred to the appropriate resource:

- Concerns regarding Workers Compensation insurance shall be referred to the Department of Labor and Industrial Relations (DOLIR), Division of Labor Standards as listed on the DOLIR website.
- Complaints regarding property destruction shall be referred to the participant’s private attorney or the local police department or sheriff’s office, as appropriate.

**PROCESS:**

Upon receipt of a complaint, DSDS shall document the information received on the attached report, along with any additional information received via collateral contacts. The report shall be forwarded to the appropriate Adult Protective and Community Supervisor (APCS) within five (5) business days. The APCS shall review the report for accuracy, enter the information into Case Compass within two (2) business days, and route the report to the Central Registry Unit (CRU) Bureau Chief for review. The CRU Bureau Chief or designee shall route the report to Department of Social Services, Missouri Medicaid Audit and Compliance (MMAC) Unit for review. There is no need to retain the report once the complaint has been entered into Case Compass.

DSDS shall document all contacts related to the complaint in the HCBS Web Tool, without including information related to ANE.

**NOTE:** The Provider Complaint Process is not to be utilized to report ANE of an eligible adult to CRU. If a provider complaint rises to the level of ANE, this information shall be forwarded to the designated Adult Protective Services (APS) contact in their Region for entry into Case Compass. The APS contact will register all necessary reports into Case Compass so they may be appropriately cross-referenced. Allegations regarding ANE shall not be recorded in Case Notes; however, Case Notes shall indicate that an “appropriate referral was made”.