Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

This renewal application includes the following major changes:

Update to Factor C to project unduplicated enrollment limits.
Revise reserved capacity language and numbers.
Updates to auditing methodology to reflect new risk-based methodology.
Updates to rates and rate methodologies.
Updates to quality metrics to align to the extent possible across Mississippi's 1915(c) waivers.
Updates to language to streamline provider qualifications.
Update Support Coordination service specifications and provider qualifications to allow for additional flexibilities in staff credentials and service provisions.
Updates to the language related to the provision of services by family members/relatives and defining legally responsible persons.
Update Level of Care determination process to replace ICAPs by independent contractor with evaluations completed by MDMH staff and remove support budgets.
Update service definitions.
Add language regarding OIG and MS Nurse Aide Abuse Registry checks.
Update language for removing individual budget limits.
Update language regarding oversight for restrictive interventions and medication management.
Update MDMH certification from three (3) years to (4) years cycle.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Mississippi** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Intellectual Disabilities/Developmental Disabilities (ID/DD)

C. Type of Request: renewal

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MS.0282
Waiver Number:MS.0282.R06.00
Draft ID: MS.009.06.00

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

07/01/23

Approved Effective Date: 07/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Intellectual Disabilities/Developmental Disabilities (ID/DD) waiver provides individuals seeking Long Term Services and Supports with meaningful choices to support residency in a Home and Community Based setting. The waiver strives to identify the needs of the person and provide services in the most cost-efficient manner possible with the highest quality of care. This is accomplished through the utilization of a comprehensive Long-Term Services and Supports (LTSS) assessment process that induced a single point of entry for individuals seeking services and is designed to fill two primary functions: 1) determine eligibility for Medicaid long term services and supports across both institutional and HCBS settings: and 2) facilitate informed choices by persons applying for services.

This waiver is administered by the Division of Medicaid (otherwise known as the State or DOM) and operated statewide by Mississippi Department of Mental Health (otherwise known as the Department or MDMH) through an interagency agreement. The following are services provided under the ID/DD Waiver: Support Coordination, Day Services-Adult, Prevocational Services, Supervised Living (including Behavioral Supervised Living and Medical Supervised Living), Supported Living, Shared Supported Living, Host Home, Supported Employment, Job Discovery, Home and Community Supports, In-Home Nursing Respite, In-Home Respite, Community Respite, Behavior Support, Crisis Support, Crisis Intervention, Transition Assistance, Therapy Services (PT, OT, ST), and Specialized Medical Supplies.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

Mississippi actively sought public input during the development of this waiver renewal by seeking comments, conducting group meetings, and meeting with providers and stakeholders. A public Input meeting was held on February 10, 2023. Attendees included providers, waiver participants, advocates and representatives of the operating agency.

The MS Provider Association invited all IDD providers to participate in a meeting on October 11, 2022, with Department of Mental Health and Division of Medicaid to discuss the ID/DD Waiver renewal and provide feedback in current services and offer recommendations for changes.

The Department of Mental Health Intellectual and Developmental Disabilities (IDD) Advisory Council is made up of IDD provider, Advocacy Groups, other State Agency representatives (such as Department of Education and MS Department of Rehabilitation Services), and person(s)/family member(s) of individuals with intellectual and developmental disabilities. The IDD Council meets quarterly to advise and support MDMH in developing IDD Services. The IDD Council met on September 16, 2022, to review services in the ID/DD Waiver and discuss possible changes for the ID/DD Waiver renewal.

Sixty days prior to submission of the waiver renewal application to CMS, the Mississippi Band of Choctaw Indians was notified via certified mail of the renewal process including proposed changes and considerations. Thirty days prior to submission of the waiver renewal application to CMS, the full draft was posted for public notice at https//Medicaid.ms.gov/news-and-notices/public-notices/.

Public input is also obtained through applicants/participants/providers call and their designated representatives, regarding inquiries, complaints, or appeals.

Summary of Public Comments & Responses:
•Remove the current age restriction & address individual skills for more independence & community integration for Supervised Living.
State's Response: DOM has reviewed the request and will continue to evaluate the need for service updates in future amendments/renewals.

•Redefine Crisis Intervention to change staffing requirements.
State’s Response: Staffing requirements for Crisis Intervention were removed from the service description & will be described in the MDMH Operational Standards & updated in the Medicaid Administrative Code.

•Create a new system of handling crisis situations in the community and/or implement a Crisis Respite Home Model.
State’s Response: At this time, DOM does not plan to create a crisis respite home model. MDMH is seeking an independent contractor to assist & make recommendations for improved crisis services. DOM/MDMH will continue to evaluate the need for service updates in future amendments/renewals.

•Ensure provision for Support Coordination to be provided by providers other than state operated programs.
State’s Response: DOM has updated the transition plan to work through system upgrades needed to support open enrollment of Support Coordination providers.

•Update day program day trip staffing ratios to 1 to 4.
State’s Response: DOM/MDHM removed staffing ratios from the service description. Staffing ratios will be addressed in MDMH Operational Standards.

•Add Transportation services & Peer Support services.
State’s Response: DOM has reviewed the requests & will continue to evaluate the need for service updates in future amendments/renewals.

•Allow Supported Employment providers to employ participants.
State’s Response: DOM does not plan to allow supported employment providers to employ participants to prevent conflict of interest.

•Allow a mobile day program option that could be provided in the home for people who do not want or can’t attend community outings.
State’s Response: DOM has reviewed & will not be adding mobile day services at this time. The ID/DD Waiver offers

other services such as In-Home Respite and Home & Community Supports.

•Create a service for sitters/attendant care while individuals are in the hospital & need a higher level of personal care while in hospitals.
State's Response: DOM does not plan to implement waiver services specific to individuals while they are receiving inpatient hospital care due to limitations on duplication of services.

•Allow for legally responsible persons to provide services, in the home, to be used under certain circumstances.
State's Response: DOM has reviewed the request & does not plan to implement a provision to allow legally responsible persons to provide services at this time. DOM/MDMH will continue to evaluate the need in future amendments/renewals.

•Make Transition Services a separate waiver services and allow them for people leaving their family home and transitioning into a supervised or supported living arrangement.
State's Response: The existing Transition Assistance Service is independent of other services. DOM does not plan to allow for transition service funds to be utilized to support transitions into facility/group settings from private homes.

•Look at providing a "paid guardianship" for certain individuals and possibly transition the Supported Decision-Making people to this service.
State's Response: At this time, DOM does not plan to implement paid guardianship services.

•Increase the rates for services in ID/DD Waiver, address staff shortages and turnover, and training requirements.
State's Response: DOM is conducting a workforce study including a comprehensive provider survey that will gather data regarding provider costs, employee recruitment and retention policies, and other best practices. Providers are encouraged to participate. That data will be incorporated into ongoing rate updates/studies.

•Implement hospital bed hold days for waiver services.
State's Response: At this time, DOM does not plan to implement bed hold days for home and community-based services.

See additional public comments in Main, B. Optional.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Day

First Name: Andrew

Title: Office Director, Office of Mental Health

Agency: Mississippi Division of Medicaid

Address: 550 High Street, Suite 1000

Address 2:

City: Jackson

State: **Mississippi**

Zip: 39201

Phone: (601) 359-6139 **Ext:** ☐ **TTY**

Fax: (601) 359-6294

E-mail: Andrew.Day@medicaid.ms.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Pinion

First Name: Betty

Title: Director, ID/DD Waiver

Agency: Mississippi Department of Mental Health

Address: Robert E. Lee Building, Suite 1101

Address 2: 239 North Lamar

City: Jackson

State: **Mississippi**

Zip: 39201

Phone: (601) 359-5797 **Ext:** ☐ **TTY**

Fax:

(601) 359-5330

E-mail:

betty.pinion@dmh.ms.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Robin Bradshaw

State Medicaid Director or Designee

Submission Date: Jun 26, 2023

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Bradshaw

First Name: Robin

Title: Office of Policy

Agency: Mississippi Division of Medicaid

Address: 550 High Street, Suite 1000

Address 2:

City: Jackson

State: **Mississippi**

Zip: 39201

Phone: (601) 359-3984 **Ext:** ☐ **TTY**

Fax: (601) 359-9521

E-mail: Robin.Bradshaw@medicaid.ms.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

DOM and DMH are actively seeking CMS guidance on two supervised living settings.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Additional Public Input Comments:

•Reduce the amount of documentation required for reinstatement of financial eligibility.
State's Response: DOM will continue to evaluate opportunities to streamline the financial eligibility redetermination process.

•Need for updates to the waitlist management process including increased transparency for providers.
State's Response: DOM will continue to evaluate opportunities to streamline waitlist management processes.

•Making sure that participants and families have choice of care coordination and service providers.
State's Response: DOM has updated the transition plan to work through system upgrades needed to support open enrollment of Support Coordination providers. Each participant has the right to choose his/her service provider and can change service provider through a request to Support Coordination. If the person is denied choice of service provider, the participant/representative should submit a grievance or complaint to DOM/MDMH.

•Update providers and participants of Appendix K measures ending May 2023.
State's Response: DOM will provide updates regarding the ending of Appendix K flexibilities prior to the end of the Public Health Emergency.

•Develop ways to reach more families about the waiver, EPSDT and managed care plans. State's Response: DOM will continue to evaluate and develop opportunities to inform families and the public about the ID/DD Waiver, EPSDT, and the managed care plans.

•Allow Participant Directed Services for the ID/DD waiver.
State's Response: At this time, DOM does not plan to utilize Participant Directed Services for the ID/DD Waiver.

•Address Specialized Medical Supply availability through the waiver.
State's Response: Specialized medical supplies are available as a State Plan Service. Part 209 of the Administrative Code addresses accessing these services.

•Request to increase Job Discovery to more than 30 hours every 3 months.
State's Response: At this time, DOM does not plan to increase Job Discovery over 30 hours every 3 month. DOM will continue to evaluate the need for increased hours.

•Improve access to speech, occupational, and physical therapy services.
States' Response: DOM will continue to evaluate opportunities to increase access to therapy services for ID/DD Waiver beneficiaries.

•Revise and increase reserved capacity.
State's Response: DOM has added language to increase reserved capacity for priority admission to the waiver for high acuity members.

•Implementing Technology First to address lack of staff and resources in group homes.
State's Response: DOM has reviewed the request and will continue to evaluate the need for Technology First in future amendments/renewals.

•DMH Incident Management System concerns with timely review due to staffing issues.
State's Response: DMH will address with the provider any serious incidents not reported in a timely manner.

•Require each provider to develop a provider handbook and communication process for participants and families.
State's Response: DOM/MDMH will review/consider this request during Quality Improvement meetings.

•Improve and share oversight, accountability, monitoring, and safeguards for the ID/DD Waiver including participant and family access to provider audits and corrective action plans to ensure quality service are delivered.
State's Response: DOM continues to improve oversight, accountability, monitoring, and safeguards for participants and providers.

•Address individual budget allocation.
State's Response: Reassessment is needed in order to implement this process. DOM and MDMH will continue to evaluate in future amendments/renewals.

•Ensure that Support Coordinators are appropriately trained, inform participants and families when changes to service authorizations occur, and require monthly utilization reports to be reviewed with families to verify services were performed in accordance with the PSS.
State's Response: MDMH will continue to provide technical assistance and training to Support Coordinators. The participant/legal representative should receive a copy of any updated PSS' which includes any changes.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

○ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:
The Mississippi Department of Mental Health

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the

Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Through an interagency agreement, Mississippi Department of Mental Health (MDMH) is responsible for the operational management of the waiver on a day-to-day basis and is accountable to Division of Medicaid (DOM) which ensures that the waiver operates in accordance with federal waiver assurances. Functions are distributed as described below:

1) Waiver enrollment managed against approved waiver limits – MDMH notifies DOM monthly of enrollment numbers; DOM verifies that enrollment limits are not exceeded

2) Waiver expenditures managed against approved waiver levels - DOM notifies MDMH monthly of expenditures; MDMH verifies that expenditure limits are not exceeded

3) Level of care evaluations are conducted by qualified staff, and MDMH reviews/verifies that level of care has been determined prior to approving each case

4) Development, review and update of person's service plans – With the person's input a Support Coordinator develops and updates the person's service plans; MDMH reviews and approves all services on the service plan

5) Qualified provider enrollment - MDMH and DOM

6) Quality assurance and quality improvement activities - MDMH and DOM

7) Collaboration in the development of rules, policies, procedures, and information development governing the waiver program – MDMH and DOM (with DOM having the final authority)

8) Provision of case management by qualified staff – MDMH

An interagency agreement between the DOM and MDMH is maintained and updated as needed. DOM monitors this agreement to assure that the provisions specified are met. In the agreement, DOM designates the assessment, evaluation, and reassessment of the person to be conducted by qualified individuals as specified in the current waiver. All such evaluations for certification or re-certification are subject to DOM's review and approval.

DOM is responsible for (1) performing monitoring of MDMH to assess their operating performance and compliance with all rules and regulations and (2) reviewing each waiver persons' certifications, both initial and annual recertification;

MDMH is responsible for (1) ensuring that assessments, evaluations, and reassessments are conducted by qualified professionals as specified in the waiver; (2) initial and ongoing training of the Support Coordinator supervisors and individual Support Coordinator; (3) monitoring through certification process and ongoing review that the qualifications for all HCBS staff and newly hired employees are met; and (4) monitoring IDD certified providers to assure criminal background checks on personnel who provide direct care to persons on the waiver.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☒
Waiver expenditures managed against approved levels	☒	☒
Level of care evaluation	☒	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☒
Rules, policies, procedures and information development governing the waiver program	☒	☒
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 1: Number and percent of monthly enrollment reports indicating that current census and unduplicated count do not exceed estimates in the waiver. N: Number and percent of monthly enrollment reports indicating that current census and unduplicated count do not exceed estimates in the waiver. D: Total number of enrollments reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIS Tracking Spreadsheets

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM 2: Number and percent of monthly waiver expenditures reports received that, on average, are at or below the projected expenditure levels for the month. N: Number of monthly waiver expenditure reports received that. on average, are at or below the projected expenditure levels for the month. D: Number of required monthly waiver expenditure reports received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIS Tracking Spreadsheet

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM 3: Number and percent of quarterly quality improvement strategy meetings held in accordance with the requirements in the approved waiver. N: Number of quarterly quality improvement strategy meetings held in accordance with the requirements in the approved waiver. D: Total number of quarterly quality improvement strategy meetings.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIS Tracking Spreadsheet

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM 4: Number and percent of providers reviewed that meet or continue to meet HCBS settings criteria as defined by federal regulations. N: Number of providers reviewed who meet or continue to meet HCB setting criteria as defined by federal regulations. D: Total number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MDMH Certification Annual Visits/Provider Self-Assessment

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM 5: Number and percent of instances where reporting requirements of the operating agency were met in accordance to the Interagency Agreement. N: Number of instances where reporting requirements of the operating agency were met in accordance to the Interagency Agreement. D: Total number of instances where the operating agency was required to submit reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIS Tracking Spreadsheet

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When individual and/or system-wide remediation activities are warranted based on discovery and analysis. DOM will hold a quality improvement strategy meeting within 30 days with the MDMH agency to examine if any changes need to be implemented systematically. In some cases, informal actions, such as obtaining an explanation of the circumstance surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP). In instances in which a CAP is needed, the MDMH and/or provider will have 30 days to submit the written corrective action plan detailing the plan for remediation. Once DOM approves the submitted corrective action plan, the MDMH and/or provider will have 90 days to implement the approved CAP. DOM will conduct the necessary follow-up to determine the effectiveness of remediation action.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	0		☒
	☒	**Developmental Disability**	0		☒
	☒	**Intellectual Disability**	0		☒
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The state further specifies its target group(s) as follows:

None

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the state is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Prior to admission to this waiver, the Diagnostic and Evaluation Team completes a thorough comprehensive Level of Care assessment. Along with the core LOC assessment, the Support Coordinator(s) submits a person-centered plan of services and supports (PSS) outlining the specific service needs of the individual and providing an estimated projection of the total cost for services to MDMH. An oversight review is conducted by MDMH staff to ensure the person's needs are able to be met by the specified services/frequencies. If a person's needs cannot be met within the capacity of the waiver, it is explained to the applicant and a Notice of Action for a Fair Hearing is sent to them. Suggestions are given for other long term services and supports alternatives.

On average, the cost for a person's waiver services must not be above the average estimated cost for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) care approved by CMS for the current waiver year. DOM and MDMH ensure the waiver remains cost neutral.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Upon a change in the participant's condition, the Support Coordinator(s) assesses the person to determine if their health and welfare can continue to be assured through the provision of waiver services in the community. If so, a change request PSS is submitted for review. Each additional service request is thoroughly reviewed by the administrative staff at MDMH. If the service is deemed appropriate and does not threaten overall cost neutrality, the MDMH will approve the request and will notify the Support Coordinator(s) of the approval. If the additional services requested are determined to exceed the average estimated cost, then the request may be denied and the applicant/person will be notified of their right to a State Fair Hearing (Appendix F). The denial must not compromise the overall quality of care for the individual. If it is determined that the denial compromises the quality of care, an approval may be granted by management of MDMH or DOM, thereby overturning the denial. If an increase in services is denied, the person will be informed and notified of their right to request a Fair Hearing.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4150
Year 2	4150
Year 3	4150
Year 4	4150
Year 5	4150

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes
Transition of Persons from an Institutional Setting to a Home and Community Based Services (HCBS) Setting
Priority Admission of Applicants with Emergent Need to Prevent Institutionalization

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Transition of Persons from an Institutional Setting to a Home and Community Based Services (HCBS) Setting

Purpose *(describe):*

The state reserves capacity within the waiver for individuals transitioning from institutional long term care settings to a home and community-based services (HCBS) setting. Individuals must have resided in the institutional setting for a minimum of thirty (30) days with at least one (1) of those days being covered in full by Mississippi Medicaid.

If the reserved capacity is not utilized within three (3) months of the end of the waiver year, the state reserves the right to reassign the reserve capacity for others awaiting services.

Describe how the amount of reserved capacity was determined:

MDMH evaluates the number of service referrals along with waiver limits and determined that the reserve capacity outlined below, in addition to capacity reserved in other waivers, would be allocated to meet the needs of individuals wishing to transition out of institutional facilities unto a Home and Community Setting.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	150
Year 2	150
Year 3	150
Year 4	150
Year 5	150

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Priority Admission of Applicants with Emergent Need to Prevent Institutionalization

Purpose *(describe):*

The state reserves capacity within the waiver for the priority admission of applicants meeting the eligibility criteria outlined in Appendix B-1 in combination with one or more of the following criteria that may result in imminent institutionalization:

- Have experienced the death, long-term incapacitation, or loss of their primary live-in caregiver directly affecting the person's ability to remain in their home within the prior 90 days.
- Immediate specialized behavior services are needed for someone who poses a documented threat of harm to self or others and/or destruction of property. A setting with structure and specially trained staff is necessary to ameliorate or mitigate the behavior in order for the person to return to his/her living and/or day setting.
- Diversion from nursing facility placement due to need of skilled nursing care. A person must have aged out of EPSDT services and cannot receive more skilled nursing hours than was received during EPSDT. Transition to this reserved capacity is not available for 24/7 care.
- Diversion to prevent unnecessary institutionalization in nursing facilities for people who have IDD.

If the reserved capacity is not utilized within three (3) months of the end of the waiver year, the state reserves the right to reassign the reserve capacity for others awaiting services.

Describe how the amount of reserved capacity was determined:

DOM evaluated the number of service referrals along with waiver limits and determined that the reserve capacity outlined below, in addition to capacity reserved in other waivers, would be allocated to meet the needs of individuals requesting priority admission.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	50

Waiver Year	Capacity Reserved
Year 4	50
Year 5	50

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entrance into the Waiver will be on a first come-first served basis for those who meet the criteria outlined in Appendix B. The exception to this first come-first served policy is those individuals who meet the reserved capacity criteria for priority admission. Entry into the Waiver will be offered to individuals based on their date of referral for the Waiver. Individuals who are referred in excess of the waiver capacity within any given year will be placed on a waiting list.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ○ **No**
- ◉ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional state supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:

- ☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☒ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

435.110 – Parents and caretaker relatives

435.116 – Pregnant women

435.118 – Infant and children under age 19

435.145 – IV-E children (foster care and adoption assistance)

435.150 – Former foster care children to age 26

435.222 – Foster children and adoption assistance children

435.226 – Independent Foster Care Adolescents (up to age 21)

435.227 – Children with non-IE adoption assistance

1634 (c) of the Act – Disabled adult children (ages 19 and over)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

◉ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is

reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ **The following standard included under the state plan**

  Select one:

  - ○ **SSI standard**
  - ○ **Optional state supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ○ **A percentage of the Federal poverty level**

    Specify percentage:
  - ○ **Other standard included under the state Plan**

    Specify:

- ○ **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ◉ **The following formula is used to determine the needs allowance:**

  Specify:

  The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller's Trust.
- ○ **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- ◉ **Not Applicable (see instructions)**
- ○ **SSI standard**

- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- ◉ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

- ○ **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ **The following standard included under the state plan**

  Select one:

  - ○ **SSI standard**
  - ○ **Optional state supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

◉ **The following formula is used to determine the needs allowance:**

Specify:

The maintenance needs allowance is equal to the person's total income as determined under the post eligibility process which includes income that is placed in a Miller Trust.

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

  The personal needs allowance is equal to the person's total income as determined in the post eligibility process which includes income that is place in a Miller Trust.
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

○ **Other**
Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The educational/professional qualifications for evaluators for initial level of care are the same for waiver applicants and applicants for ICF/IID services. Initial evaluations are conducted in an interdisciplinary team format. Team members include at least a psychologist and social worker. Other disciplines participate as indicated by a person's individual need. All team members are appropriately licensed and certified under state law by their respective disciplines. There are 5 Diagnostic and Evaluation Teams (D&E Teams) that conduct evaluations and are located at each of MDMH's five (5) IDD Regional Programs.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

To complete an initial LOC evaluation, the Diagnostic and Evaluation Team administers a battery of assessment instruments to each individual. The instruments chosen include standardized measures of intellectual and adaptive functioning such as the Wechsler Child and Adult Intelligence Scales, Vineland Adaptive Behavior Scales, and other standardized instruments deemed appropriate for each individual. As a part of the evaluation process, the Inventory for Client and Agency Planning (ICAP) is completed. The following criteria are used to establish level of care:

All definitions for intellectual disability will be based on the definitions in the most current Diagnostic and Statistical Manual of Mental Disorders (DSM).

To qualify for the Waiver, an individual must have one of the following:

An intellectual disability characterized by significant limitations in both intellectual functioning and adaptive behavior. The individual's IQ score is approximately 70 or below and the disability originates before age 18.

Or

Persons with closely related conditions who have a severe, chronic disability that meets ALL of the following conditions:

1. It is attributable to:
   a. Cerebral palsy or epilepsy; or
   b. Any other condition, other than mental illness, found to be closely related to intellectual disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals intellectual disabilities and requires treatment or services similar to those required for these persons; or
   c. Autism as defined by the most current DSM.
2. It is manifested before the person reaches age 22; and
3. It is likely to continue indefinitely; and
4. It results in substantial functional limitations in three or more of the following areas of major life activity:

   a. Self-care.
   b. Understanding and use of language.
   c. Learning.
   d. Mobility.
   e. Self-direction.
   f. Capacity for independent living.
   g. Economic self-sufficiency.

People must have a Broad Independence Standard Score on the ICAP of 69 or below to meet the recertification criteria for the ID/DD Waiver. People having Broad Independence Standard Score of 70 or above will be flagged in the LTSS System and referred to the appropriate Diagnostic and Evaluation Team for a clinical review of all records to determine if he/she continues to meet ICF/IID LOC. If a person whose Broad Independence Standard Score is 70 or above, and, in the professional opinion of the psychologist, continues to meet ICF/IID LOC, he/she will remain enrolled. If the psychologist determines the person does not continue to meet ICF/IID LOC, the person will be discharged and referred to other appropriate services such as the IDD Community Support Program (1915i), Targeted Case Management or Community Support Services through a Community Mental Health Center. The person will be afforded all rights to appeal the decision.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

  Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The specific battery of assessment instruments chosen for initial evaluations includes standardized measures of intellectual and adaptive functioning such as the Wechsler Child and Adult Intelligence Scales, Vineland Adaptive Behavior Scales, and other standardized instruments which measure intellectual and adaptive functioning and are deemed appropriate for each individual. Medical, social and other records necessary to have a current and valid reflection of the individual are also reviewed. As a part of the evaluation process, the Inventory for Client and Agency Planning (ICAP) is completed by the Diagnostic and Evaluation Team. The ICAP contains all but three (3) of the required elements for the Core Standardized Assessment. Those items not contained (transferring, mobility in bed, and bathing), are asked separately in order to provide information related to a person's need for support in these areas but scoring is not impacted.

For reevaluation of LOC, the ICAP is administered at least annually by each person's Support Coordinator. If there is an increase of a person's score that changes his/her Support Level by one (1) or more levels, a review by the Diagnostic and Evaluation Team may take place to determine the reason for the increase.

People must have Broad Independence Standard Score of <70 to meet the recertification criteria for the ID/DD Waiver. People having Broad Independence Standard Score of 70 or above will be flagged in the LTSS System and referred to the appropriate Diagnostic and Evaluation Team for a clinical review of all records to determine if he/she continues to meet ICF/IID LOC. If a person whose Broad Independence Standard Score is 70 or above, in the professional opinion of the psychologist, continues to meet ICF/IID LOC, he/she will remain enrolled. If the psychologist determines the person does not continue to meet ICF/IID LOC, the person will be discharged and referred to other appropriate services such as the IDD Community Support Program (1915i), Targeted Case Management or Community Support Services through a Community Mental Health Center. The person will be afforded all rights to appeal the decision.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**

  Specify the qualifications:

Reevaluations of level of care are conducted by ID/DD Waiver Support Coordinators. Support Coordinators hold at least a Bachelor's degree in a human services field with no experience required or at least a Bachelor's degree in a non-related field with at least one-year relevant experience. Support Coordinators are supervised by a person with a Master's degree with at least two years of relevant experience. Relevant experience means experience working directly with persons with intellectual/developmental disabilities or other type of disabilities or mental illness.

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

In the eLTSS system, a recertification packet is initiated, and the Support Coordinator is sent an alert 90 days prior to the expiration of the current certification period. This prompt encourages Support Coordinator(s) to begin recertification activities in advance to ensure recertifications and prevent lapses in eligibility. Also, DOM provides the MDMH with a monthly Eligibility Report, which includes person's name, the end date of the certification period, and the end date for Medicaid financial eligibility. The report ensures that Support Coordinators are aware of any person that is about to lose eligibility or waiver services. The report is reviewed by the Support Coordinator(s) and any discrepancies are reported to DOM for resolution.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The person's original record is maintained in eLTSS. The core standardized assessments along with other required documentation is submitted electronically which produces a copy that is retained in the eLTSS system under the current federal guidelines. MDMH and the State have access to all information required for initial and recertification through LTSS.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 1: Number and percent of waiver applicants, where there is a reasonable indication that services may be needed in the future that a received an ICF/IID level of care evaluation N: Number and percent of waiver applicants, where there is a reasonable indication that services may be needed in the future that a received an ICF/IID level of care evaluation D: Total number of waiver applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:

LTSS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 2: Number of initial & recert assessments completed by qualified assessors where the processes & instruments were accurately applied as described in the approved waiver. N: Number of initial & recert assessments completed by qualified assessors where the processes & instruments were accurately applied as described in the approved waiver. D: Total number of initial & recert assessments reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTSS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

In any instance in which it is discovered that a participant was not evaluated/reevaluated by a qualified assessor in accordance with the procedures outlined in Appendix B of this waiver, DOM will hold a quality improvement strategy meeting with the operating agency within 30 days to examine if any changes need to be implemented systemically. The operating agency will be required to ensure a qualified assessor conducts a LOC evaluation within fifteen (15) days of the discovery. If it is identified at that time that the participant does not meet the criteria, the participant will be 1) removed from the planning list if not currently enrolled or 2) disenrolled from the waiver and receive notice of their appeal rights in accordance with Appendix F of this waiver. If disenrolled, the Support Coordinator will be required to explore other community or public funded services that may be available to the individual and assist with any referrals to those resources. Claims for the period of ineligibility identified will be reviewed and recouped appropriately.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The ID/DD Waiver process requires the person or their legal representative to sign and attest to their choice of setting and waiver on an Informed Choice form. Long term services and supports options are explained by the Support Coordinator(s) prior the enrollment, and the person indicates their choice of waiver services or institutional services by evidence of their selection and signature.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The person's original record in maintained, either electronically or in paper, at the operating agency offices. The Informed Choice along with other required documentation is submitted electronically which produces a copy that is retained in the eLTSS system. The operating agency is required to keep the entire document for the period of time specified under the current federal guidelines.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State subscribes to a language line service that provides interpretation services for incoming calls from the person with limited English proficiency (LEP). The subscribed interpretation service provides access in minutes to persons who interpret English into as many as 140 languages. Each Medicaid Regional office is set up with an automated access code under the State identified code.

The State has established a Limited English Proficiency (LEP) Policy. All essential staff have received training on the use of the Language Line Service. All necessary steps have been taken to ensure staff understand the established LEP policy and are capable of carrying it out.

The key to the telephone language interpreter service is to provide meaningful access to benefits and services for LEP persons, and to ensure that the language assistance provided results in accurate and effective communication between the Division of Medicaid and individuals about the types of services and/or benefits available, and about the person's circumstances.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Day Services - Adult**		
Statutory Service	**In-Home Respite**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Supervised Living**		
Statutory Service	**Support Coordination**		
Statutory Service	**Supported Employment**		
Statutory Service	**Supported Living**		
Extended State Plan Service	**Specialized Medical Supplies**		
Extended State Plan Service	**Therapy Services**		
Other Service	**Behavior Support Services**		
Other Service	**Community Respite**		
Other Service	**Crisis Intervention**		
Other Service	**Crisis Support**		
Other Service	**Home and Community Supports**		
Other Service	**Host Home**		
Other Service	**In-Home Nursing Respite**		
Other Service	**Job Discovery**		
Other Service	**Shared Supported Living**		
Other Service	**Transition Assistance**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Services - Adult

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Day Services-Adult is the provision of regularly scheduled, individualized activities in a non-residential setting, separate from the person's private residence or other residential living arrangements. Group and individual participation in activities that include daily living and other skills that enhance community participation and meaningful days for each person are provided. Personal choice of activities as well as food, community participation, etc. is required and must be documented and maintained in each person’s record.

Services must optimize, not regiment individual initiative, autonomy and independence in making informed life choices including what he/she does during the day and with whom they interact. Day Services-Adult must have a community component that is individualized and based upon the choices of each person. Transportation must be provided to and from the program and for community participation activities.

The setting location must be located in the community so as to provide access to the community at large including shopping, eating, parks, etc. to the same degree of access as someone not receiving ID/DD Waiver services. The setting must be physically accessible to persons. Settings where Day Services Adult are provided must meet all federal standards for HCBS settings.

Day Services-Adult includes assistance for people who cannot manage their personal toileting and hygiene needs during the day. People who have a high level of support need must be offered the opportunity to participate in all activities, including those offered on site and in the community.

People must be at least 18 years of age. Anyone under the age of 22 must have documentation in their Plan of Services and Supports to indicate he/she has completed their education and is no longer attending school.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

One unit of service equals 15 minutes. The provider must submit claims in 15-minute increments for the duration of time the services were provided and will be reimbursed by DOM the lessor of the maximum cap as stated in Appendix I for each waiver year or the total amount of the 15-minute increment units billed. The provider must provide services during normal business hours and must be open for at least six continuous hours per day. The duration of the service time should begin upon the person's entry in the facility and end upon their departure.

People receiving Day Services-Adult may also receive Prevocational Services but not at the same time of day. Maximum hours for one service or combination of the two services cannot exceed 138 hours per month.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Day Services Adult Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Services - Adult

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Day Services Adult Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH Certification

Other Standard *(specify):*

People receiving Day Services-Adult may also receive Prevocational Services but not at the same time of day. Maximum hours for one service or combination of the two services cannot exceed 138 hours per month.

Providers must comply with Title 23 of the Mississippi Administrative Code. Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Day Services Adult staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

In-Home Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

In-Home Respite provides temporary, periodic relief to those persons normally providing care for the eligible individual. The individual is unable to leave the home unassisted, requires 24-hour assistance of the caregiver, and/or unable to be left alone or unsupervised for any period of time. In-home respite services are provided in the family home and is not permitted for individuals living independently, either with or without a roommate. In Home Respite personnel are not permitted to provide medical treatment as defined in the MS Nursing Practice Act and Rules and Regulations. In-Home Respite staff cannot accompany individuals to a medical appointment.

In-Home Respite is not available for people who receive Supported Living, Supervised Living, Shared Supported Living, Host Home services, or who live in any other type of staffed residence.

In-Home Respite is not available to individuals who are in the hospital, an ICF/IID, nursing home, or other type of rehabilitation facility that is billing Medicaid, Medicare, and/or private insurance This includes inpatient psychiatric facilities.

In-Home Respite staff provides all the necessary care the usual caregiver would provide during the same time period. Activities are to be based upon the outcomes identified in the Plan of Services and Supports and implemented through the Activity Support Plan. Allowable activities include:

1. Assistance with personal care needs such as bathing, dressing, toileting, grooming
2. Assistance with eating and meal preparation for the person receiving services
3. Assistance with transferring and/or mobility
4. Assistance with cleaning the individual’s personal space
5. Leisure activities

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

One unit of service equals 15 minutes of relief to the caregiver. In-Home Respite will be approved based upon needs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver In Home Respite Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: In-Home Respite

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver In Home Respite Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH certification

Other Standard *(specify):*

Providers must comply with Title 23 of the Mississippi Administrative Code. Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

In-Home Respite is not available for people who receive Supported Living, Supervised Living, Shared Supported Living, Host Home, or who live independently or in any other type of staffed residence.

Family members are allowed to provide In-Home Respite if employed by a certified MDMH provider. Family members are required to meet all personnel and training requirements as required for all in-home respite staff as outlined in the MDMH Operational Standards. The following types of family members are excluded from being providers of In-Home Respite: (1) anyone who lives in the same home with the person, regardless of relationship; (2) parents/step-parents, spouses, or children of the person receiving the services; (3) those who are normally expected to provide care for the person receiving the services including legal guardians, conservators, power of attorney, or representative payee of the person's Social Security benefits.

Family members providing in-home respite must be identified in the Plan of Services and Supports. Family members will only be authorized to provide a maximum of up to forty (40) hours per week or one-hundred seventy-two (172) hours per month.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all In-Home Respite staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Prevocational Services provide meaningful activities of learning and work experiences, including volunteer work, where the person can develop general, non-job task specific strengths and skills that contribute to paid employment in integrated community settings. Prevocational Services are expected to be provided over a defined period of time with specific outcomes to be achieved as determined by the person and his/her team. There must be a written plan to include job exploration, work assessment, and work training. The plan must also include a statement of needed services and the duration of work activities.

People receiving Prevocational Services must have employment related outcomes in their Plan of Services and Supports; the general habilitation activities must be individualized and designed to support such employment outcomes. Prevocational Services must enable each person to attain the highest level of work in an integrated setting with the job matched to the person's interests, strengths, priorities, abilities and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills associated with building skills necessary to perform work in a competitive, integrated employment.

Participation in Prevocational Services is not a prerequisite for Supported Employment. A person receiving Prevocational Services may pursue employment opportunities at any time to enter the general work force. At least annually, providers will conduct an orientation informing people receiving services about Supported Employment and other competitive employment opportunities in the community. This documentation must be maintained on site. Representative(s) from the Mississippi Department of Rehabilitation Services must be invited to participate in the orientation.

Settings where Prevocational Services are provided must meet all federal standards for HCBS settings. The setting must be physically accessible to persons. Prevocational Services may be furnished in a variety of locations in the community and are not limited to fixed program locations. Community job exploration activities must be offered to each person based on choices/requests of the persons and be provided individually or in small groups. Documentation of the choices offered, and the chosen activities must be documented in each person's record. People who have a high level of support need must be included in community job exploration activities. Transportation must be provided to and from the program and for community integration/job exploration.

Mobile crews and entrepreneurial models that do not meet the definition of Supported Employment and that are provided in groups of up to three (3) people can be included in Prevocational Services away from the program site and be documented as part of the Plan of Services and Supports.

People must be at least 18 years of age. Anyone under the age of 22 must have documentation in their Plan of Services and Supports to indicate he/she has completed their education and/or is no longer attending school.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

People receiving Prevocational Services may also receive Day Services-Adult but not at the same time of day. Maximum hours for one or combination of the two services cannot exceed 138 hours per month.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Prevocational Service Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Prevocational Service Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH Certification

Other Standard *(specify):*

People receiving Prevocational Services may also receive Day Services-Adult but not at the same time of day. Maximum hours for one or combination of the two services cannot exceed 138 hours per month.

Students aging out of school services must be referred to the Mississippi Department of Rehabilitation Services and exhaust those Supported Employment benefits before being able to enroll in Prevocational Services.

Providers must comply with Title 23 of the Mississippi Administrative Code. Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Prevocational service workers.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Supervised Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supervised Living Services provide individualized tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of a person's day. Activities must support meaningful days for each person. Activities are to be designed to promote independence yet provide necessary support and assistance. Agency providers should focus on working with the person to gain independence and opportunity in all life activities. Providers must ensure each person's rights of privacy, dignity and respect and freedom from coercion. Services must optimize, but not regiment, a person's initiative, autonomy and independence in making life choices, including, but not limited to daily activities, physical environment, and with whom to interact. Supervised Living services must include supports, as appropriate to each person's needs, for direct personal care assistance and instrumental activities of daily living.

Persons must have choice of residential settings including non-disability specific settings as documented in their Plan of Services and Supports (PSS). Supervised Living is provided in a MDMH certified setting. Settings where Supervised Living services are provided must meet all federal standards for HCBS settings. Any modification or restriction to HCBS requirements must be supported by a specific assessed need and justified in the Plan of Services and Supports. Individual rooms are preferred, but no more than two persons may share a bedroom. Persons must have keys to their home and their room if they so choose. There must be at least one staff person in the same dwelling as people receiving services at all times (24/7) that is able to respond immediately to the requests/needs for assistance from the persons in the dwelling. The amount of staff supervision someone receives is based on tiered levels of support based on a person's Support Level determined by the Inventory for Client and Agency Planning (ICAP).

Nursing services are a component of Supervised Living Services and must be provided in accordance with the MS Nurse Practice Act. Examples of nursing activities include monitoring vital signs or blood sugar; administration of medication; weight monitoring, and accompanying people on medical appointments, etc. Non-licensed personnel may assist a person with medication usage for certain procedures not requiring a nurse to perform as outlined in the MDMH Operational Standards once completion of all training requirements are met.

Persons must have control over their personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. There must be documentation in each person's record regarding all income received and expenses incurred and how/when it is reviewed with the person. Persons must have a lease or written financial agreement and afforded the rights outlined in the Landlord/Tenant laws of the State of Mississippi (MS Code Ann. 1972 §89-7-1 to125 and §89-8-1 to 89-8-1 to 89).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Supervised Living Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supervised Living

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Supervised Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH certification

Other Standard *(specify):*

Persons with high frequency disruptive behaviors that pose serious health and safety concerns to self and/or others may be approved an increased reimbursement rate. Providers must demonstrate staffing and ability to provide the increased level of support, meet MDMH Behavioral Supervised Living Operational Standards, and be certified by MDMH to provide this level of support. Documentation and justification for this level of support must be submitted to MDMH through each person's PSS and approved by the MDMH Specialized Needs Committee review prior to authorization of increased rate. Persons approved for behavioral supervised living level of support cannot also be approved for Behavior Support

Persons with chronic physical or medical conditions requiring prolonged dependency on medical treatment in which skilled nursing intervention is necessary may be approved an increased reimbursement rate. Providers must demonstrate increased staffing and ability to provide the increased level of support, meet MDMH Medical Supervised Living Operational Standards, and be certified by MDMH to provide this level of support. Documentation and justification for this level of support must be submitted to MDMH through each person's PSS and approved by the MDMH Specialized Needs Committee review prior to authorization of increased rate.

MDMH Specialized Needs Committee is comprised of at least a Registered Nurse, a Licensed Psychologist. and a consultant specializing in behavior modification and analysis.

Providers must comply with Title 23 of the MS Administrative Code. Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Supervised Living workers.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Support Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Support Coordination shall mean the assessment, planning, implementing, coordination, and monitoring of services and supports that assist people with intellectual and developmental disabilities to participate in their community, increase independence and control over their own lives to the greatest extent possible, and develop skills and abilities needed to achieve his/her personal goals. Support Coordination shall be provided in a manner that comports fully with federal standards applicable to person-centered planning. Support Coordination activities include coordinating and facilitating the development of the Plan of Services and Supports through the person-centered planning process and revising/updating each individual's Plan of Services and Supports at least annually or when changes in the individual's circumstances occur or when requests are made by the individual/legal guardian. Support Coordination shall oversee at least annual reassessment of the person's level of care eligibility. Support Coordination also conducts at least annual assessment of the individual's experience to confirm that the setting in which the person is receiving services including those requirements applicable to provider owned/controlled settings meet federal HCBS requirements, except as supported by the person's specific assessed need and documented in the Plan of Services and Supports.

Support Coordination activities include, but are not limited to, informing the person and legal representative about all ID/DD Waiver and non-waiver services from which the person could benefit; providing the person choice of certified providers and settings (as applicable to the service) initially, annually, if he/she becomes dissatisfied with the current provider, when a new provider/site is certified in that person's area, or if a provider's certification status changes; and linking the person to services and supports chosen. Support Coordination must inform the person/legal representative when all services are approved, denied, reduced, or terminated and the procedures for appealing those determinations. Support Coordination must educate the person/legal representatives on individual rights and procedures to submit a grievance/complaint and reporting instances of abuse, neglect and exploitation.

Support Coordination provides monitoring and assessment of the individual's Plan of Services and Supports that must include information about the individual's health and welfare, including any changes in health status, needs for support, preferences, progress and accomplishments, and or changes in desired outcomes; information about the individual's satisfaction with current service(s) and provider(s); addressing the need for any new services (ID/DD Waiver and non-waiver); addressing whether the amount/frequency of service(s) listed on the approved Plan of Services and Supports remains appropriate; and review of utilization of services via a report generated by the MDOM. Support Coordinators are mandatory reporters of any suspicion or instance of abuse, neglect or exploitation and are required to report serious incidents as outlined in MDOM Administration Code and MDMH Operational Standards. Support Coordination is required to contact the person/legal representative at least monthly via telephone and conduct face-to-face visits with each individual/and legal guardian at least once every three (3) months, rotating service settings and talking to staff. More frequent telephone or face-to-face visits may be required depending on the person's circumstances or need for assistance. For people who receive only day services, at least one (1) visit per year must take place in the person's home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service equals all Support Coordination activities provided in one month. Support Coordination reimbursement is a flat rate which is billed monthly after the service is provided. Support Coordinators are required to visit the person on a monthly basis and Support Coordination services are centered in the home of the person.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Support Coordination Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Support Coordination

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Support Coordination Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH certification

Other Standard *(specify):*

Providers must comply with Title 23 of the Mississippi Administrative Code. Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Support Coordination staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
03 Supported Employment	03022 ongoing supported employment, group
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Before a person can receive Supported Employment services, he/she must be referred by his/her Support Coordinator to the MS Department of Rehabilitation Services to determine his/her eligibility for services from that agency. Documentation must be maintained in the person's record that verifies the service is not available under an agency provider funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et. Seq.). People must be at least 18 years of age. Anyone under the age of 22 must have documentation in their Plan of Services and Supports to indicate he/she has completed their education and are no longer attending school.

Supported Employment is ongoing support for people who, because of their support needs, will need intensive, ongoing services to obtain or maintain a job in competitive, integrated employment or self-employment. Employment must be in an integrated work setting in the general workforce where an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported Employment does not include volunteer work or unpaid internships.

Providers must work to reduce the number of hours of staff involvement as the employee becomes more productive and less dependent on paid supports. This is decided on an individualized basis based on the job. The amount of support is decided with the person and all staff involved as well as the employer, the Department of Rehabilitation Services and the person's team.

Supported Employment Services are provided in a work location where individuals without disabilities are employed; therefore, payment is made only for adaptations, supervision, and training required by individuals receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Other workplace supports may include services not specifically related to job skills training that enable the individual to be successful in integrating into the job setting (i.e., appropriate attire, social skills, etc.).

Providers must be able to provide all activities that constitute Supported Employment as outlined in MDMH Operational Standards. Job Development activities assist an individual in determining the best type of job for him/her and then locating a job in the community that meets those stated desires. Job Maintenance activities assist an individual to learn and maintain a job in the community. Supported Employment may also include services and supports that assist the individual in achieving self-employment through the operation of a business, either home-based or community-based.

Transportation will be provided between the individual's place of residence for job seeking and job coaching as well as between the site of the individual's job or between day program sites as a component part of Supported Employment. Transportation cannot comprise the entirety of the service. If local or other transportation is available, the individual may choose to use it but the provider is ultimately responsible for ensuring the availability of transportation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Individuals cannot receive Supported Employment during the Job Discovery process.

Job Development is limited to ninety (90) hours per certification year. Additional hours may be approved by MDMH on an individual basis with appropriate documentation. The amount of Job Maintenance a person receives is dependent upon individual need, team recommendations, and employer evaluation and as justified in the Plan of Services and Support.

Self-employment is limited to max of fifty-two (52) hours per month of at home assistance by a job coach, including business plan development and assistance with tasks related to producing the product and max of thirty-five (35) hours per month for assistance in the community by a job coach. Payment is not made for any expenses associated with starting up or operating a business. Referrals for assistance in obtaining supplies and equipment for someone desiring to achieve self-employment should be made to the Mississippi Department of Rehabilitation Services. There must be documentation of the referral in the person's record.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Supported Employment Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Supported Employment Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH Certification

Other Standard *(specify):*

Providers must comply with Title 23 of the Mississippi Administrative Code. Waiver specific provider enrollment and compliance requirements are detailed in Part 208 of the code. Providers must also comply with MDMH Operational Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all supported employment staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Supported Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported Living Services are provided to people age eighteen (18) and above who reside in their own residences (either owned or leased by themselves or a certified agency provider) for the purposes of increasing and enhancing independent living in the community. Supported Living Services are for people who need only intermittent support, less than twenty-four (24) hour staff support per day. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency. Activities are designed to promote independence yet provide necessary support and assistance based on each person's individual needs. Agency providers should focus on working with the person to gain independence and opportunity in all life activities.

The person may choose to rent or lease in a MDMH certified supervised living, shared supported living, or supported living location for four (4) or fewer individuals. All provider owned or controlled settings must meet HCBS federal setting requirements. Providers must ensure each person's rights of privacy, dignity and respect and freedom from coercion. Services must optimize, but not regiment, a person's initiative, autonomy and independence in making life choices, including, but not limited to daily activities, physical environment, and with whom to interact. Persons have choices about housemates and with whom they share a room. Persons must have keys to their home and their room if they so choose.

Nursing services are a component of Supported Living Services and must be provided in accordance with the MS Nurse Practice Act. Examples of nursing activities include monitoring vital signs or blood sugar; administration of medication; weight monitoring, and accompanying people on medical appointments, etc. Non-licensed personnel may assist a person with medication usage for certain procedures not requiring a nurse to perform as outlined in the MDMH Operational Standards once completion of all training requirements are met.

Persons must have control over their personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. For persons living in provider owned/controlled settings, there must be documentation in each person's record regarding all income received and expenses incurred and how/when it is reviewed with the person. Persons must have a lease or written financial agreement and afforded the rights outlined in the Landlord/Tenant laws of the State of Mississippi (MS Code Ann. 1972 §89-7-1 to125 and §89-8-1 to 89-8-1 to 89).

Individuals in Supported Living cannot also receive: Supervised Living, Shared Supported Living, In-Home Nursing Respite, In-Home Respite, Home and Community Supports, or Community Respite or live in other type staffed residence. Supported Living cannot be provided to someone who is an inpatient of a hospital, ICF/IID, nursing facility, inpatient psychiatric facility or any type of rehabilitation facility when the inpatient facility is billing Medicaid, Medicare or private insurance.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of service hours are determined by the level of support required for the person. The maximum amount of hours shall not exceed eight (8) hours per twenty-four (24) hour period.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Supported Living Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Living

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Supported Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH certification

Other Standard *(specify):*

Supported Living Services for community participation activities may be shared by up to three (3) people who may or may not live together and who have a common direct service provider. In these cases, people may share Supported Living personnel when agreed to by the people and when the health and welfare can be assured for each person.

Providers must comply with Title 23 of the MS Administrative Code. Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all supported living staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supplies covered under the waiver include only specified types of catheters, diapers, pull-ups, and under pads. These items must be specified on the PSS. Items reimbursed with waiver funds shall be those items which are deemed as medically necessary for the individual. Medicaid waiver funds are to be utilized as a payor of last resort. Request for payment must be made to other payers (i.e. Medicare, State plan, and private insurance) prior to submission of billing request to utilize waiver funds.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

If it is determined through the person-centered planning process that supplies and case management are the only services needed by an applicant, the applicant would not meet waiver eligibility.

The services under the ID/DD waiver are limited to additional services not covered under the state plan, including EPSDT.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment (DME)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment (DME)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DME providers must be certified as a DME supplier under Title XVII (Medicare) of the Social Security Act and provide current documentation of their authorization to participate in the Title XVII program to DOM.

Other Standard *(specify):*

DME providers must meet all applicable requirements of law to conduct business in the State and must be enrolled as a Medicaid provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The DOM fiscal agent.

Frequency of Verification:

Will be verified by DOM fiscal agent when enrolled and when original certification expires.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Therapy Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Therapy services are Physical Therapy (PT), Occupational Therapy (OT), and Speech/Language Therapy (ST) are only reimbursable under the ID/DD Waiver for persons over the age of 21 that receive therapy in their home or MDMH certified day program setting. Therapies are not reimbursable under the ID/DD Waiver at a therapist office/clinic, outpatient department of a hospital, or physician office/clinic that are covered in the State Plan. Therapy services should only be provided in the beneficiary's home or MDMH certified day program setting when it is not feasible to be rendered in a provider's office, clinic, or hospital setting and cannot be strictly for convenience of the person or their family. Therapy services must be justified in the Plan of Services and Supports with an order or prescription indicating medical necessity of therapy(ies); justification why therapy(ies) cannot be rendered as an outpatient in a provider's office, clinic, or hospital setting; and the duration of the therapy(ies). These therapy services cannot be provided through the waiver when available through the IDEA (20 U.S.C. 1401 et seq.) or through Expanded EPSDT.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

One unit of service equals fifteen minutes. Maximum of 3 hours per week of physical therapy allowed. Maximum of 3 hours per week of speech therapy allowed. Maximum of 2 hours per week of occupational therapy allowed.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Approved Agency
Individual	MS Medicaid Enrolled Physical Therapist, Occupational Therapist and Speech-Language Pathologist (Speech Therapist)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Approved Agency

Provider Qualifications

License *(specify):*

Individuals providing therapy services must be licensed by the State in their respective discipline.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Agencies who are Medicaid enrolled providers and who contract with individuals or group or employ individuals to provide therapy services must ensure compliance with all state licensures, regulations and/or guidelines for each respective discipline. DOM fiscal agent requires certification for initial provider enrollment.

Frequency of Verification:

Will be verified by DOM fiscal agent when enrolled and when original certification expires.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Therapy Services

Provider Category:

Individual

Provider Type:

MS Medicaid Enrolled Physical Therapist, Occupational Therapist and Speech-Language Pathologist (Speech Therapist)

Provider Qualifications

License *(specify):*

The Physical, Occupational, and Speech therapist must meet the state and federal licensing and/or certification requirements in their respective discipline to perform therapy services in the State of Mississippi. The therapist must have a current and active license issued by the appropriate licensing agency for their respective discipline to practice in the State of Mississippi.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The DOM fiscal agent requires therapy providers be licensed by the State in their respective discipline for initial provider enrollment.

Frequency of Verification:

Will be verified by the DOM fiscal agent when enrolled and when original license expires. The expiration date of the license is maintained in the MMIS. The provider must submit a current license at time of expiration. If current license is not submitted, the provider file is closed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavior Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Behavior Support provides systematic behavior assessment, Behavior Support Plan development, consultation, restructuring of the environment and training for individuals whose maladaptive behaviors are significantly disrupting their progress in learning, self-direction or community participation and/or are threatening to require movement to a more restrictive setting or removal from current services. This service also includes consultation and training provided to families and staff working with the individual. The desired outcome of the service is long-term behavior change. If at any time an individual's needs exceed the scope of the services provided through Behavior Support, the individual will be referred to other appropriate services to meet his/her needs.

The Behavior Consultant conducts a Functional Behavior Assessment through on-site observation of the person and interview with person, family, and service providers to determine if a Behavior Support Plan is warranted. A medical evaluation for physical and/or medication issues must be conducted prior to completion of the Functional Behavior Assessment and before a Behavior Support Plan can be implemented. If it is determined a Behavior Support Plan is not warranted, the Behavior Consultant provides informal training of staff and other caregivers regarding positive behavior support techniques. If the Behavior Consultant determines ongoing Behavior Support is needed, the Behavior Consultant develops the Behavior Support Plan. The Behavior Consultant implements the Behavior Support Plan to the degree determined necessary, trains the Behavior Interventionist and other caregivers in the implementation of the plan, monitors and reviews data submitted by the Behavior Interventionist to determine successful implementation of the Behavior Support Plan, and determines when the Functional Behavior Assessment and/or Behavior Support Plan needs revision. Functional Behavioral Assessments are updated every two (2) years unless the person has substantial changes to: his/her circumstances (living arrangements, school, caretakers); the person's skill development or performance of previously established skills; or frequency, intensity or types of challenging behaviors.

Behavior Interventionists are responsible for participating in the continued development of the Behavior Support Plan with the Behavior Consultant; implementing the Behavior Support Plan through face-to-face training with service providers and/or caregivers; monitoring service providers and/or caregivers with their interaction with the person and implementation of the Behavior Support Plan; collecting and analyzing data for the effectiveness of the Behavior Support Plan; and submitting documentation to the Behavior Consultant which documents progress toward successful implementation of the plan.

Behavior Support can be provided simultaneously with other waiver services if the purpose is to conduct a Functional Behavior Assessment; provide direct intervention; modify the environment; or provide training to staff/parents on implementing and maintaining the Behavior Support Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Behavior Support is not restricted by the age of the individual; however, it may not replace educationally related services provided to individuals when the service is available under EPSDT, IDEA or other sources such as an IFSP through First Steps or is otherwise available. All other sources must be exhausted before waiver services can be approved. This does not preclude a Behavior Consultant from observing an individual in his/her school setting, but direct intervention cannot be reimbursed when it takes place in a school setting.

Behavior Support cannot be billed for a person receiving Behavioral Supervised Living as behavior support is included as part of the increased reimbursement rate for person with significant behavioral issues.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Behavior Support Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Support Services

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Behavior Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH Certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Behavior Support staff.

Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Respite

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Respite is provided in a MDMH certified community setting that is not a private residence and is designed to provide caregivers an avenue of receiving respite while the individual is in a setting other than his/her home. The service location must be located in the community so as to provide access to the community at large including shopping, eating, parks, etc. to the same degree of access as someone not receiving HCBS. Settings where Community Respite services are provided must meet all federal standards for HCBS settings.

Community Respite is designed to provide caregivers a break from constant care giving and provide the individual with a place to go which offers activities to maintain or enhance personal skills and greater independence. Activities are designed around the person's interests as identified in the Plan of Services and Supports. Adults and children cannot be served together in the same area of the building. There must be a clear separation of space and staff.

Community Respite is not used in place of regularly scheduled day activities such as Supported Employment, Day Services-Adult, Prevocational Services or services provided through the school system.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Individuals who receive Host Home, Supervised Living, Shared Supported Living or Supported Living or who live in any type of staffed residence cannot receive Community Respite.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Community Respite Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Respite

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Community Respite Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH Certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Community Respite staff.

Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Crisis Intervention

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Crisis Intervention provides short-term behavior-oriented services for a person who is experiencing a behavioral crisis which is likely to threaten the health and safety of the person or others, result in significant property damage, and/or may result in the person's removal from his/her current living arrangement. Upon receiving information that someone is in need of Crisis Intervention, the agency immediately sends trained personnel to the person to assess the situation and provide direct intensive support. As soon as feasible, the person must be evaluated by medical personnel to determine if there are any physical/medication factors affecting his/her behavior. Appropriate qualified personnel analyze the psychological, social, and environmental components of the extreme dysfunctional behavior or other factors contributing to the crisis to develop the most effective strategies and interventions to ameliorate the situation. The Crisis Intervention team continues to provide intensive direct supervision/support to include assisting the person with personal care needs when the primary caregiver is unable to do so because of the nature of the person's crisis situation. Crisis Intervention may be authorized for up to twenty-four (24) hours per day in seven (7) day segments with the goal of phasing out of Crisis Intervention services in a manner that ensures the health and welfare of the person and those around him/her. Additional seven (7) day segments may be approved by MDMH, depending on the person's needs and situational circumstances. Crisis Intervention may also be provided episodically in short-term (less than 24 hour) segments if there is reasonable expectation, based on past occurrences or immediate circumstances that indicate the person cycles into intensive behaviors based on serious mental illness or certain identified triggers. The outcome of Crisis Intervention is to phase out the support as the person becomes more able to maintain him/herself in a manner which allows him/her to participate in daily routines and able to return to his/her home living and/or day setting. Crisis Intervention Services are used in situations in which the need is immediate and exceeds the scope of Behavior Support Services. If an individual requires a higher level of supervision/support than can be safely provided through Crisis Intervention services, he/she will be appropriately referred to other more intensive services. Crisis Intervention may be provided in the individual's home, in an alternate community living setting and/or in the person's usual day setting.

The provider must develop policies and procedures for locating someone to an alternate residential setting(s). This includes the type of location, whether individuals will be alone or with others, and plans for transporting individuals. The policies and procedures must include a primary and secondary means for providing an alternate residential setting(s). These settings must be equipped with all items necessary to create a home like environment for the individual.

Crisis Intervention Services may be indicated on an individual's Plan of Services and Supports prior to a crisis event when there is a reasonable expectation, based on past occurrences or immediate situational circumstances in which the individual is at risk of causing physical harm to him/herself, causing physical harm to others, damaging property, eloping, or being unable to control him/herself in a manner that allows participation in usual activities of daily life. The provider will be chosen at the time the service is approved on the Plan of Services and Supports; therefore, if a crisis arises, the provider can be dispatched immediately.

The provider must have an on-call system that operates 24 hours a day, seven (7) days per week to ensure there is sufficient staff available to respond to crises.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Crisis Intervention is authorized for up to twenty-four (24) hours per day in seven (7) day segments. Episodic Crisis Intervention services can be authorized for up to 168 hours per certification year. Additional seven (7) day segments or episodic hourly Crisis Intervention must be approved by MDMH.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Crisis Intervention Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Crisis Intervention Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH Certification

Other Standard *(specify):*

Crisis Intervention providers must meet staffing requirements as outlined in the MDMH Operational Standards. Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Crisis Intervention staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Crisis Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Crisis Support is provided in an intermediate care facility for individual with intellectual/developmental disabilities (ICF/IID) or MDMH certified crisis facility and is used when a person's behavior or family/primary caregiver situation becomes such that there is a need for immediate specialized services that exceed the capacity for Crisis Intervention or Behavior Support Services. Such situations involve:

1. Behavioral Issues – person has exhibited high risk behavior placing themselves and others in danger of being harmed; directly causing serious injury of such intensity as to be life threatening or demonstrates the propensity to cause serious injury to self, others, or animals; sexually offensive behaviors; less intrusive methods have been tried and failed; criminal behavior; and/or serious and repeated property destruction.
2. Family/Other Issues – the primary caregiver becomes unexpectedly incapacitated or passes away and the person's support needs cannot be adequately met by other ID/DD Waiver services; the person is in need of short-term services in order to recover from a medical condition that can be treated in an ICF/IID rather than a nursing facility; or the primary caregiver is in need of relief that cannot be met by other ID/DD Waiver services.

Crisis Support includes medical care, nutritional services, personal care, behavior services, social and/or leisure activities as deemed appropriate. Crisis Intervention or Behavior Supports is not a pre-requisite for Crisis Support services. Crisis Support is time limited in nature. A transition discharge planning meeting is required with the person, legal representative, Crisis Support team, Support Coordinator, and community service providers to assure services and supports are in place when ready for discharge.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Crisis Support is provided for a maximum of thirty (30) days per stay. Additional days must be authorized by MDMH.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Crisis Support Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Support

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Crisis Support Providers

Provider Qualifications

License *(specify):*

Mississippi Department of Health ICF/IID

Certificate *(specify):*

MDMH certified crisis facility

Other Standard *(specify):*

Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all MDMH certified crisis facility providers. The provider agency verifies the qualifications are met for all Crisis Support staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home and Community Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home and Community Supports (HCS) is for individuals who live in the family home and assists the person with personal care and support activities within the home as well as in the community. Home and Community Supports provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) such as bathing, toileting, transferring and mobility, meal preparation, assistance with eating and incidental household cleaning and laundry which are essential to the health, safety, and welfare of the individual. Other activities can include assistance with keeping appointments, access to community resources and social and leisure activities available to all people. Activities are individualized based on what is important to and for the person as identified in the Plan of Services and Supports. HCS staff are responsible for providing transportation to and from community outings within the scope of the service. The person must be monitored at all times during service provision whether in the person's home, during transportation, and during community outings. HCS staff may assist individuals with shopping needs and money management, but may not disburse funds on the part an individual without written authorization from the legal guardian, if applicable. HCS staff are not permitted to provide medical treatment as defined in the MS Nursing Practice Act and Rules and Regulations. HCS staff cannot accompany a minor on a medical visit without a parent/legal representative present. HCS cannot be provided in the HCS staff's home unless the staff is an approved family member providing the service that also lives with the person.

Home and Community Supports may be shared by up to three (3) individuals who have a common direct service provider agency. Individuals may share HCS staff when agreed to by the participants and the health and welfare can be assured for each participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Family members providing HCS must be identified in the Plan of Services and Supports. Family members will only be authorized to provide a maximum of up to forty (40) hours per week or one-hundred seventy-two (172) hours per month. Family members are required to meet all personnel and training requirements as required for all in-home respite staff as outlined in the MDMH Operational Standards. HCS providers employing family members must provide unannounced quality assurance visits at least once every three (3) months.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Home and Community Supports Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home and Community Supports

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Home and Community Supports Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH certification

Other Standard *(specify):*

Home and Community Supports cannot be provided in a school setting or be used in lieu of school services. HCS is not available for individuals who receive Supported Living, Shared Supported Living, Supervised Living, or who live in any other type of staffed residence. HCS is not available to individuals who are in the hospital, an ICF/IID, nursing home or other type of rehabilitation facility that is billing Medicaid, Medicare, and/or private insurance.

The state does not make payments for furnishing HCS to:
-The spouse of a person supported; the parent, stepparent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption.
-The legal guardians/legal representative, conservators, power of attorney, and/or representative payee for Social Security benefits.

Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all HCS staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Host Home

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02023 shared living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Host Homes are private homes where no more than one individual who is at least five (5) years of age lives with a family and receives personal care and other supportive services. There may be only one (1) person in the home receiving Host Home services. Each person receiving Host Home services must have his/her own bedroom and the agency provider is responsible for basic furnishings.

Host Home Families are a stand-alone family living arrangement in which the principal caregiver in the Host Home assumes the direct responsibility for the participant's physical, social, and emotional well-being and growth in a family environment. Host Home services include assistance with personal care, meals, leisure activities, social development, family inclusion, community inclusion, and access to medical services. Natural supports are encouraged and supported. Supports are to be consistent with the participant's support level, goals, and interests.

Host Homes are administered and managed by agency providers that are responsible for all aspects of Host Home Services. Host Home agencies must: complete an evaluation of each Host Home family and setting; conduct background checks for Host Home family members; provide training; ensure each Host Home family member has had a medical examination at least annually; and maintain current financial and property records for the person served. Host Home agencies have twenty-four (24) hour responsibility for the Host Homes which includes back-up staffing for scheduled and unscheduled absence of the Host Home family with plan in place to provide care until another suitable living arrangement can be secured. Host Home providers are responsible for the health and safety of the person served and must conduct at least monthly home visits to each home and more often if needed. Host Home providers must ensure the Host Home family arranges and takes the person for medical appointments, dental care, and other identified supports. People receiving Host Home Services must have access to the community to the same degree as people not receiving services. The Host Home family must follow all aspects of the person's Plan of Services and Supports. Host Home services must meet all federal HCBS regulations. Any modification or restriction to HCBS requirements must be supported by a specific assessed need and justified in the Plan of Services and Supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum number of waiver participants who may live in a Host Home is one (1). To receive services, a person must be at least five (5) years of age. If under the age of five (5), prior approval from the MDMH is required.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Host Home Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Host Home

Provider Category:

Agency

Provider Type:

Host Home Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH certification

Other Standard *(specify):*

Individuals receiving Host Home cannot also receive: Supervised Living, Shared Supported Living, Home and Community Supports, In-Home Respite, In-Home Nursing Respite, Supported Living or Community Respite.

Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf..

Verification of Provider Qualifications

Entity Responsible for Verification:

MDMH/Medicaid

Frequency of Verification:

Initially and at least every 4 years thereafter. Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

In-Home Nursing Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

In-Home Nursing Respite provides temporary, periodic relief to those persons normally providing care for the eligible individual. In-Home Nursing Respite is provided for people who require skilled nursing services, as prescribed by a physician, in the absence of the primary caregiver. The individual is unable to leave the home unassisted, requires 24-hour assistance of the caregiver, and/or unable to be left alone or unsupervised for any period of time. In-Home Nursing Respite services are provided in the family home and is not permitted for individuals living independently, either with or without a roommate. In-Home Nursing Respite cannot be provided in the provider's residence. Staff cannot accompany the person to medical appointments. Activities are to be based upon the outcomes identified in the Plan of Services and Supports. In-Home Nursing Respite staff also provide non-medical activities to include, but not limited to assistance with personal care needs such as bathing, dressing, toileting, and grooming; assistance with eating and meal preparation for the person receiving services; assistance with transferring and/or mobility, and assisting with leisure activities.

Individuals must have a statement from their physician/nurse practitioner stating the treatment(s) and/or procedure(s) the individual needs in order to justify the need for a nurse in the absence of the primary caregiver; the amount of time needed to administer the treatment(s)and/or/procedure(s); and how long the treatment(s) and/or procedure(s) are expected to continue.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver In-Home Nursing Respite Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In-Home Nursing Respite

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver In-Home Nursing Respite Agency

Provider Qualifications

License *(specify):*

In-Home Nursing Respite must be provided by a registered nurse (RN) or a licensed practical nurse (LPN) and services must be provided within their scope of practice according to the MS Nursing Practice Act Rules and Regulations.

Certificate *(specify):*

MDMH Certification

Other Standard *(specify):*

A person cannot receive In-Home Nursing Respite if he/she qualifies for Private Duty Nursing through Early Periodic Screening Diagnostic and Treatment (EPSDT). In-Home Nursing Respite is not available for people who receive Supported Living, Supervised Living, Shared Supported Living, or who live in any other type of staffed residence. In-Home Nursing Respite is not available to individuals who are in the hospital, an ICF/IID, nursing home, or other type rehabilitation facility that is billing Medicare, Medicaid, or private insurance. A family member is not allowed to provide In-Home Nursing Respite.

Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all In-Home Nursing staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Job Discovery

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Job Discovery is the person-centered process to assist a person in determining the type of job best fits the person's unique interests and his/her abilities, skills, and support needs. Job Discovery staff must receive or participate in Customized Employment training as specified by MDMH and use those skills to develop a Job Discovery Profile for the person. Job Discovery includes, but is not limited to, face-to-face interviews with the person and people who know the person well; review of current and previous supports and services; observation of the neighborhood and local community to determine nearby employment, services, transportation, and safety concerns; observation of and participation with the person in typical life activities outside of his/her home; and participation in a familiar activity in which person is at his/her best and most competent. Job Discovery assists the person discover opportunities in job exploration, job shadowing, and internships. Job Discovery also includes other person-centered services such as, but not limited to interviewing skills, job and task analysis activities, environmental and work culture assessments and resume development. Job Discovery may include business plan development for self-employment and development of an employment/career plan.

Job Discovery staff must refer the person to the MS Department of Rehabilitation Services to begin the eligibility process for Supported Employment. The person must also be referred to Community Work Incentives Coordinator at the MS Department of Rehabilitation Services to determine the impact of income on benefits.

Persons eligible for Job Discovery include a person who is an adult (age eighteen or older) and has never worked; a person who has previously had two (2) or more unsuccessful (e.g., were fired for behaviors, inability to perform, etc.) employment placements; a person with multiple disabilities who cannot represent him/herself and has previously or never been successful in obtaining community employment; or a person who has had a significant change in life situation/support needs that directly affects his/her ability to find and maintain a job.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Job Discovery cannot exceed thirty (30) hours of service over a three (3) month period. Additional monthly increments/hours must be justified and prior authorized by the MDMH.

Individuals who are currently employed or who are receiving Supported Employment Services cannot receive Job Discovery services. A person cannot receive Pre-Vocational Services and/or Day Services-Adult at the same time of day as Job Discovery.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Job Discovery Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Job Discovery

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Job Discovery Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH Certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Job Discovery staff.

Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Shared Supported Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02033 in-home round-the-clock services, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Shared Supported Living Services are for people age eighteen (18) and older. Shared Supported Living is a 24/7 residential service provided in a compact geographical location such as an apartment complex in residences either owned or leased by themselves or through a certified provider. Employee supervision is provided at the service location and in the community but does not include direct employee supervision at all times. The amount of employee supervision someone receives is based on tiered levels of support on the Inventory for Client and Agency Planning (ICAP). There must be awake staff twenty-four (24) hours per day, seven (7) days per week when people are present in their living unit and must be available to respond to the person when needed. Persons must have choice of residential settings including non-disability specific settings as documented in their Plan of Services and Supports (PSS). Shared Supported Living is provided in a MDMH certified setting. Settings where Shared Supported Living services are provided must meet all federal standards for HCBS settings. Any modification or restriction to HCBS requirements must be supported by a specific assessed need and justified in the Plan of Services and Supports.

Shared Supported Living Services provide individualized tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of a person's day. Transportation is included in the service. The person is supported to live, work, and engage in community activities to the greatest extent possible. Activities must support meaningful days for each person, promote independence, and provide necessary support and assistance as identified in the Plan of Services and Supports. Providers must ensure each person's rights of privacy, dignity and respect and freedom from coercion. Services must optimize, but not regiment, a person's initiative, autonomy and independence in making life choices, including, but not limited to daily activities, physical environment, and with whom to interact.

Shared Supported Living Services must assist people in arranging and accessing routine and emergency medical care and monitoring their health and/or physical condition. Nursing services are a component of Shared Supported Living Services and must be provided in accordance with the MS Nurse Practice Act. Examples of nursing activities include monitoring vital signs or blood sugar; administration of medication; weight monitoring, and accompanying people on medical appointments, etc. Non-licensed personnel may assist a person with medication usage for certain procedures not requiring a nurse to perform as outlined in the MDMH Operational Standards once completion of all training requirements are met.

Persons must have control over their personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. There must be documentation in each person's record regarding all income received and expenses incurred and how/when it is reviewed with the person. Persons must have a lease or written financial agreement and afforded the rights outlined in the Landlord/Tenant laws of the State of Mississippi (MS Code Ann. 1972 §89-7-1 to125 and §89-8-1 to 89-8-1 to 89).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Individuals in Shared Supported Living cannot also receive: Supervised Living, Host Home services, In-Home Nursing Respite, In-Home Respite, Home and Community Supports, Supported Living or Community Respite.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Shared Supported Living Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Shared Supported Living

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Shared Supported Living Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH Certification

Other Standard *(specify):*

Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Shared Supported Living staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transition Assistance

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Transition Assistance is a one (1) time set up expense for people who transition from institutions (ICF/IIDs or nursing facilities) to the ID/DD Waiver. The person may move to a less restrictive community living arrangement such as a house or apartment with ID/DD Waiver supports or home with their family with ID/DD Waiver supports.

To be eligible for transition assistance the following is necessary: the person cannot have another source to fund or attain the items or support; the person must be transitioning from a setting where these items were provided for him/her and upon leaving the setting they will no longer be provided; the person must be moving to a residence where these items are not normally furnished; and the person's institutional stay is not acute or for rehabilitative purposes. Items bought using these funds are for personal use and are to be property of the person if he/she moves from a residence owned or leased by a provider.

Examples of expenses that may be covered as Transition Assistance are transporting furniture and personal possessions to the new living arrangement; linens and towels; cleaning supplies; security deposits required to obtain a lease on an apartment or home; utility set-up fees or deposits for utility or service access (e.g., telephone, water, electricity, heating, trash removal); initial stocking of the pantry with basic food items for the person receiving services; health and safety assurances such as pest eradication, allergen control or one-time cleaning prior to moving; essential furnishings include items for a person to establish his or her basic living arrangements such as a bed, table, chairs, window blinds, eating utensils, and food preparation items.

Transition Assistance services shall not include monthly rental or mortgage expenses, regular utility charges, and/or household appliances or recreational electronics such as TV, DVD players, game systems, or computers.

After the person moves, the provider submits a claim to the State for the dollar amount of the items, up to the approved maximum reimbursement rate. If the total amount of purchases exceeds the approved maximum reimbursement rate, the provider will only be paid up to that amount. The provider must maintain receipts for all items purchased in the person's record and sends copies to the ID/DD Waiver Support Coordinator.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transition Assistance is a one-time, life-time maximum of $800 per person.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MS Medicaid Enrolled ID/DD Waiver Transition Assistance Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition Assistance

Provider Category:

Agency

Provider Type:

MS Medicaid Enrolled ID/DD Waiver Transition Assistance Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

MDMH Certification

Other Standard *(specify):*

Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf.

Verification of Provider Qualifications

Entity Responsible for Verification:

Mississippi Division of Medicaid is responsible for the credentialing of all providers. MDMH is responsible for certification of all providers. The provider agency verifies the qualifications are met for all Transition Assistance staff.

Frequency of Verification:

Qualifications are verified upon enrollment/hire and thereafter as needed.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

A national criminal background check with fingerprints must be conducted on all individuals providing all ID/DD Waiver services in accordance with Title 23 of the Mississippi Administrative Code. Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf. Compliance with mandatory background check requirements is ensured through post payment audit activities as outlined in Appendix I of this waiver. The Mississippi Division of Medicaid is responsible for the credentialing of all providers and for ensuring that background checks are conducted on owners/operations in accordance with the regulations. Provider agencies are responsible for ensuring background checks are conducted on their employees in accordance with Part 208 of the Mississippi Medicaid Administrative Code.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Screenings of the Mississippi Nurse Aide Registry (maintained by the MS Department of Health) and the Office of Inspector General's Exclusion Database must be conducted by provider agencies on all individuals providing direct ID/DD Waiver services in accordance with Part 208 of the Mississippi Medicaid Administrative Code. Waiver specific provider enrollment and compliance requirements for these providers can be found in Rule 5.5 (page 91-118) of Part 208 of the Administrative Code available at https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-208.pdf. Providers must also comply with MDMH Operational Standards (pages 13 - 22) available at https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf. Compliance with mandatory screening requirements is ensured through post payment audit activities as outlined in Appendix I of this waiver.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

◉ **Other policy.**

Specify:

The state does not make payments for furnishing waiver services to legal guardians or legal representatives, including but not limited to, spouses, parents/stepparents of minor children, conservators, guardians, individuals who hold the participant's power of attorney or those designated as the participant's representative payee for Social Security benefits. For the purposes of this requirement, relatives are defined as any individual related by blood or marriage to the participant.

The state may allow payments for furnishing waiver services to non-legally responsible relatives only when the following criteria are met:
- The selected relative is qualified to provide services as specified in Appendix C-1/C-3.
- The participant or another designated representative is available to sign verifying that services were rendered by the selected relative.
- The selected relative agrees to render services in accordance with the scope, limitations and professional requirements of the service during their designated hours.

Providers employing a family member to serve as In-Home Respite and Home and Community Supports, regardless of relationship or qualifications, must maintain the following documentation in each staffs' personnel record:

-Proof of address for the family member seeking to provide services is required. Proof of address is considered to be a copy of a lease, rental agreement, or utility bill that includes that person's name. If required documentation cannot be obtained, the family member seeking to provide services must provide a signed and notarized affidavit that includes his/her current address, evidencing the fact that he/she does not live in the same home as the person receiving services.
-Evidence the individual's ID/DD Waiver Support Coordinator has been notified the agency is seeking approval of a family member to provide In-Home Respite and Home and Community Supports.
-Participant or other designated representative is available to sign verifying that services were rendered by the selected relative.

-Providers must conduct drop-in, unannounced quality assurance visits during the time the approved family member is providing services. These visits must occur at least two (2) times per year.

Documentation of these visits must be maintained in the staff's personnel record. Documentation must include:
1. Observation of the family member's interactions with the person receiving services
2. Review of Plan of Services and Supports and Service Notes to determine if outcomes are being met
3. Review of utilization to determine if contents of Service Notes support the amount of service provided

The State reserves the right to remove a selected relative from the provision of services at any time if there is the suspicion, or substantiation, of abuse/neglect/exploitation/fraud or if it is determined that the services are not being professionally rendered in accordance with the approved Plan of Services and Supports. If the state removes a selected relative from the provision of services, the participant will be asked to select an alternate qualified provider.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All willing and qualified providers of Medicaid services may apply to the state to become a Medicaid provider. Medicaid providers agree to abide by Medicaid policy, procedure, rules and guidance.

Provider enrollment information along with the credentialing requirements for each provider type and timeframes are available via the DOM website.

MDMH's website has information regarding requirements and procedures for becoming a MDMH certified provider. Additionally, online provider orientation sessions are conducted to inform potential providers of the process, requirements, and timeframes for becoming a MDMH certified provider. The MDMH Operational Standards contain the processes and procedures for becoming a MDMH certified provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 1: Number & percent of providers who met, and continue to meet, required certification standards in accordance with waiver qualifications throughout service provision. N: Number of providers who met, and continue to meet, required certification standards in accordance with waiver qualifications throughout service provision. D. Total number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MDMH Certification Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 2: The state does not have non-licensed or non-certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
NA

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: N/A	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: N/A
	☒ **Other** Specify: N/A	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: N/A	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: N/A

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 3: Number and percent of provider staff training records that document training requirements as outlined in the DMH Operational Standards N: Number of provider staff training records that document training requirements as outlined in the MDMH Operational Standards D: Number of provider staff training records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Financial and Performance Audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Other** Specify: Every 24 months

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

MDMH certified provider agencies are certified on a four (4) year cycle. During that time, providers are reviewed to determine compliance with DMH Operational Standards. If deficiencies are found, MDMH provider agencies must submit a Plan of Compliance within thirty (30) days or sooner, following identification of issues, if indicated by MDMH. Plans of Compliance must address each identified deficiency, how each was remediated and the provider agency's plan for continued compliance with the MDMH Operational Standards along with timelines for each remedial activity. MDMH reviews and approves or disapproves all Plans of Compliance. In order to ensure remedial activities have been completed, MDMH requires the submission of evidence of corrective action and/or follows up with an on-site visit to ensure compliance. Should a Plan of Compliance not be acceptable or implemented as approved, MDMH may exercise its authority to suspend or terminate a provider agency's MDMH certification.

In addition to the possibility of suspension or termination of certification based on an unacceptable Plan of Compliance, MDMH certified providers can also have their certification status affected for egregious acts such as endangerment of the health and welfare of an individual being served, unethical conduct, or failure to comply with fiscal requirements.

MDMH notifies the State when provider agency certifications are suspended or terminated. MDMH certification is a requirement of receiving/retaining a Medicaid provider number. Therefore, the State will then suspend or terminate the agencies provider number until the provider agency is recertified by MDMH. Termination of an agency provider number will require the provider to reapply to the State to reinstate their provider number and provide documentation of recertification by MDMH.

In addition, The Department of Mental Health's Division of Certification Site Review Team, when monitoring providers who provide services other than ID/DD Waiver, reviews personnel records specifically of ID/DD Waiver staff to determine compliance with qualifications and training. Upon each certification visit, the provider must present a list of all personnel by service area. The MDMH Division of Certification reviews a random sample of personnel records from each ID/DD Waiver service. All findings are documented on the Written Report of Findings form for each ID/DD Waiver service area.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Mississippi Division of Medicaid received notice from the Center for Medicare and Medicaid Services (CMS) of Final Approval of the Statewide Transition Plan on July 11, 2022. The State outlined the State's efforts in bringing Home and Community Based Services (HCBS) into full compliance prior to the March 17, 2023 transition period deadline. All non-residential settings (Day Services Adult, Prevocational Services, and Community Respite) and residential settings (Supervised Living, Shared Supported Living, and Supported Living – owned and controlled by the provider) were assessed and brought into compliance through remediation, with the exception of two settings which were submitted to CMS for Heightened Scrutiny review. Although the State determined the two settings met federal HCBS settings requirements pertaining to service provision, the settings were referred to CMS due to their location. One supervised living setting is adjacent to a nursing facility and one supervised living setting is adjacent to a private ICF/IID.

Ongoing monitoring is crucial to assure continued compliance with the HCBS Final Rule. MDMH will provide ongoing monitoring of compliance with the HCBS Final Rule across all HCBS through certification of services and settings. Current certified ID/DD Waiver providers are surveyed through MDMH Certification each year. Any areas of noncompliance will result in a Written Report of Findings and subsequent remediation process. MDMH may take administrative action to suspend, revoke, or terminate certification. MDOM will be notified of any such administrative action. New interested providers must also go through the Certification process which includes review of policies and procedures to ensure compliance with MDMH Operational Standards including Final Rule requirements and an on-site inspection of each new setting prior to service provision and with all newly certified agencies providing HCBS (including non-setting-based services) within six (6) months of beginning service provision. MDMH staff will also conduct an on-site visit and survey of random sample of at least two people from each new setting certified under new providers within one (1) year of beginning service provision. Any areas of noncompliance will be identified through a Written Report of Findings, followed by Plan of Compliance, and validation by MDMH that strategies were implemented.

Support Coordinators are required to complete person-centered training and use those techniques in developing a person-centered plan (Plan of Services and Supports – PSS) for each individual. Through monthly contact(s) Support Coordinators follow up to see the PSS is implemented. Support Coordinators also are trained on federal HCBS settings requirements and will monitor and follow up on issues of noncompliance. Support Coordinators complete a Final Rule Monitoring Tool at least annually which includes interview with the person/legal representative and service providers (as needed). The Monitoring Tool will be submitted with the person's recertification packet. Support Coordinators will consult with MDMH as needed. Any unresolved issues must be followed up on until resolved. Unresolved or egregious issues of noncompliance will be reported to MDMH/Certification and result in appropriate administrative action. MDMH will conduct Technical Assistance and training opportunities for Support Coordinators and certified providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Services and Supports

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

Qualified providers of case management services, known as Support Coordination, must meet the requirements set by the State and MDMH to become a provider. Support Coordination must be certified through the Department of Mental Health. Agencies certified to provide Support Coordination cannot provide any other ID/DD Waiver Service and must be able to provide state-wide coverage for all people in the ID/DD Waiver from the first day of operation.

Staff qualifications for Support Coordinators are outlined in Appendix B-6.h, Qualifications of Individuals who Perform Re-Evaluations. Support Coordinators hold at least a Bachelor's degree in a human services field with no experience required or at least a Bachelor's degree in a non-related field with at least one-year relevant experience. Support Coordinators are supervised by a person with a Master's degree with at least two years of relevant experience. Relevant experience means experience working directly with persons with intellectual/developmental disabilities or other type of disabilities or mental illness.

The State will implement a process to ensure open enrollment for all willing and qualified providers for Support Coordination services. Case Management agencies must have a statewide network of Support Coordinators. The State will transition from the current case management system to the one outlined above by December 31, 2024. The State is developing a plan to enroll potential providers and will submit this plan for CMS approval as soon as possible. Interested providers should contact the Department of Mental Health and complete the process for certification as other ID/DD waiver providers. Once certification is received, the provider would then apply to the Division of Medicaid to become a Medicaid waiver provider.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the

service plan development process and (b) the participant's authority to determine who is included in the process.

Each person is meaningfully and actively engaged in the development and maintenance of the PSS in several ways. The person, either alone or with assistance from a chosen representative, chooses the individuals he/she would like to have attend the development/review of the PSS. The PSS development includes discussing options, desires, individual strengths, personal goals, emergency preparedness needs, specific needs of the person, and how those needs can be best met. The meeting is held at a time and location of the person's choosing. Additionally, he/she requests the types and amounts of service(s) he/she would like to receive, as well as the provider(s) he/she would like to have render the services.

Throughout the person's certification year, the Support Coordinator has at least monthly (or more frequently, if needed) contact with the person. Providers are contacted on a quarterly basis. During these contacts, the Support Coordinator is able to gather information from the person regarding any adjustments that are needed to the PSS or to the Activity Support Plan which guides the daily provision of services at the provider level. The Support Coordinator communicates this information, when needed, to the provider and revises the PSS accordingly.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The development of the Plan of Services and Supports is driven by the person-centered planning process. The person/legal representative (if applicable), the Support Coordinator, provider staff and others of the person's choosing to participate in the development of the PSS. The Support Coordinator writes the PSS to include information gathered during the PSS meeting to include what is important to and for the person, likes and dislikes, and preferences and goals. Outcomes are developed by the person and his/her PSS team centered around the person's goals and assigned to each service and/or natural supports. The PSS must be reviewed at least annually or when changes in support needs arise or when requested by the person. Copies of the PSS must be provided to the person/legal guardian and all providers listed in the PSS
except DME suppliers or therapy providers.

Before initial enrollment in the ID/DD Waiver, people must be evaluated by one of the state's five (5) Diagnostic and Evaluation Teams (D&E Teams) for eligibility for level of care. The Inventory for Client and Agency Planning (ICAP) is also administered as part of the initial assessment. After the assessment for enrollment, the person-centered planning meeting that leads to the development of the PSS is also considered to be part of the assessment. As part of that, the state chose the ICAP as the Core Standardized Assessment to be used to assess functional needs. A person's support needs are continually being assessed through monthly and quarterly contacts by the Support Coordinator with him/her and/or the legal representative, if applicable and with his/her providers. Adjustments to the PSS and/or Activity Support Plans are made when the person/legal guardian requests such or as support needs change.

The person is informed about all certified providers before he/she is initially certified and at least annually thereafter, when new providers are certified, or if the person becomes dissatisfied with his/her provider. The Support Coordinator is knowledgeable about all available ID/DD Waiver services and certified providers.

In Supervised Living, Shared Supported Living, Supported Living and Host Homes, providers are required to document each visit a person makes to a health care professional. This documentation includes the reason for the visit and the healthcare provider's instructions, including monitoring for any potential for any unwanted side effects of any prescribed medication(s). This documentation is reviewed by all staff and the review is documented via their signature and credentials on the form.

Support Coordinators are also required to inquire about each person's healthcare needs and any changes in such during monthly and quarterly contacts. Additionally, the Division of Medicaid provides a Monthly Utilization Report to Support Coordinators that lists all Medicaid services a person receives each month. The report has a lag time of two (2) months. This is one (1) tool the Support Coordinator can use to determine whether the person is receiving services in accordance with their PSS, or if the person has been to the doctor, been hospitalized, or changed medications.

Healthcare needs are also addressed with providers. Providers are contacted as part of quarterly contact documentation to ascertain how their services are assisting the person in meeting stated outcomes. One of the questions is to review any changes in a person's health status.

The coordination of waiver and other services is a constant activity for Support Coordinators. Through at least monthly contacts, the Support Coordinator is able to determine which services are being utilized, what new services may be needed, and what services may need to be reviewed to determine if the provider is supporting stated outcomes in the PSS. Through at least quarterly face-to-face contacts in the person's service setting(s) Support Coordinators are able to observe the person, talk with him/her and talk with provider staff to ensure
all services he/she receives are adequate and appropriate to support outcomes in the PSS.

Any needed back-up arrangements are discussed during the development of the PSS. Types of back-up arrangements include emergency contact information for staff; provider arrangements for a different staff person if the regularly schedule one cannot be present; natural supports, including neighbors, families and friends; use of generators or evacuation procedures in case of power outages if the person requires electricity powered medical devices; other personally tailored arrangements depending on his/her support needs.

The Support Coordinator is responsible for ensuring all services are implemented as approved on the person's PSS. This is accomplished through monitoring service provision during monthly phone contacts, on-site and face-to-face visits, and Monthly Utilization Reports from Medicaid.

The PSS is reviewed monthly and updated at least annually. A change in the PSS can be requested by the person/legal

guardian at any time. The Support Coordinator is responsible for coordinating any requests for changes and submitting the required information for such to MDMH for approval/denial/modification. All increases or additional amount(s)/type(s) of services must be prior approved by MDMH.

There must be justification to support the need for a change if it is a change in the amount of service(s) or addition of a service(s).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The presence and effect of risk factors are determined during the LTSS assessment and PSS process. The assessment is specifically designed to assess and document risks an individual may possess. The PSS includes identified potential risk to the person's health and welfare. These risk factors are identified as concerns that cause significant impact to the person's life, functional capacity and overall health and safety. Risk factors include documented instances of abuse/neglect/exploitation, socially inappropriate behavior, communication deficits, nutrition concerns, environmental security and safety issues, falls, disorientation, emotional/mental functioning deficits, and lack of informal support.The person's involvement and choice are used to develop mitigation strategies for all identified risk. The person, along with caregivers/supports, is included in developing strategies and are encouraged to comply with strategies to help mitigate risk and ensure health and safety. This is assured by ongoing monitoring by the Support Coordinator. Monthly and quarterly actions are required to review/assess the person's service needs, with a new PSS developed every twelve months.

Back up plans are developed by the Support Coordinator(s) in partnership with the person and their family/caregiver upon admission. The PSS must include back up staff who will provide services when the assigned staff is unable to provide care. The person and/or their caregiver identify family members and/or friends who are able to provide services/support in the event of an emergency. During a community disaster or emergency, the Support Coordinator contacts the person and their family/caregiver to assess immediate needs. The Support Coordinator notifies the Support Coordinator supervisor, who then may notify the local first response team (i.e. the Mississippi Emergency Management Agency) of persons with special needs who may require special attention.

The development of the PSS also includes developing an emergency preparedness plan (EPP) for all persons. The EPP includes emergency contact information as well as outlining the individual's evacuation plan/needs in case of a fire or natural disaster.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the person-centered planning process, the person and/or their caregiver is given a list of qualified provider(s)/vendor(s) to choose from in their service area to be included in their PSS. The person and/or their representative review the list of qualified provider(s)/vendor(s) to determine which one would best meet the needs, preferences, and goals of the person. The person and/or representative is given an opportunity in some instances to meet the provider(s)/vendor(s) prior to the selection in order to make a more informed choice. The person may choose one or multiple providers. Providers are not allowed to require participants to bundle all services through one agency. Once all options are taken into consideration, the person and/or caregiver selects the provider(s)/vendor(s) they feel best meets their needs. The selected provider is documented on the Choice of Provider form which is then signed by the person or caregiver acknowledging their free choice of provider. This form is then uploaded into LTSS for MDMH review.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

After the person understands the criteria for the waiver, meets clinical eligibility, and has made an informed choice, the PSS is developed by the Support Coordinator which includes all of the service needs, personal goals and preferences of the person. Through an Interagency Agreement with the operating agency (MDMH), the DOM has delegated approval of the PSS to the operating agency. All Plans of Services and Supports (PSS), are submitted in LTSS in the electronic Long Term Services and Supports (eLTSS) case management system. DOM is notified of MDMH's determination and finalizes enrollment or recertification into the waiver.

MDMH and DOM meet quarterly and as needed to address any issues with individual PSS' and issues overall.

MDMH staff reviews all initial and recertification requests. Change Request PSSs resulting in an increase or addition in amount/type of service are reviewed by MDMH staff. Documentation of MDMH's action is maintained in LTSS. The State has immediate access to all MDMH actions and can review documentation used to make decisions at any time.

The PSS development is led by the participant to the extent possible and includes services/supports of their choosing to meet their needs. The plans also address the individuals' goals and preferences.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- (●) **Every three months or more frequently when necessary**
- ( ) **Every six months or more frequently when necessary**
- ( ) **Every twelve months or more frequently when necessary**
- ( ) **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- [ ] **Medicaid agency**
- [ ] **Operating agency**
- [ ] **Case manager**
- [x] **Other**

Specify:

All Plans of Services and Supports are entered electronically in LTSS. The State and MDMH staff have access to Plans of Services and Supports at any time. Support Coordination Directors can access PSSs for everyone assigned to their catchment area. Support Coordinators can access PSSs of people assigned to their caseload.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The PSS is the fundamental tool by which the State ensures the health and welfare of waiver persons enrolled in the waiver. The State's process for developing a person's PSS requires the plan to be based on a person-centered planning process which identifies the needs, preferences, and goals for the person. A Support Coordinator(s) along with the person and others as requested by the person are jointly responsible for the development of the PSS.

Quarterly face-to-face visits with each person enrolled in the waiver by the Support Coordinator are required to determine the appropriateness and effectiveness of the waiver services and to ensure that the services furnished are consistent with the person's needs, goals and preferences. Additional monthly contacts, either face-to-face or by phone/video, with the person provide the Support Coordinator the ability to evaluate whether services are provided in accordance with the PSS.

If service provision in accordance with the PSS is found to be inconsistent during the monitoring process, the case management agency contacts the service provider to engage in a problem-solving process to determine how to get the person the services needed in a consistent manner in accordance with the PSS.

Review of monitoring findings are conducted as a component of the state's Quality Improvement Strategy outlined in Appendix H in order to detect and address any systemic issues.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The Support Coordinator monitors the person-centered service plan and can only provide other waiver services to the person if there are no other willing providers in the geographic area and there are appropriate firewalls in place. Support Coordination is currently provided by four (4) of five (5) State IDD Regional Programs. Support Coordination is being opened to private providers effective December 31, 2024. The State IDD Regional Programs provide Crisis Support at their ICF/IID for persons with need of immediate specialized services that exceed the capacity of Crisis Intervention or Behavior Support. There has been no interest from private ICF/IIDs in the State or other qualified crisis providers. MDMH is considering opening certified ID/DD crisis facilities in the future. As 100% of person-centered Plans of Services & Supports (PSS) are approved by the MDMH, case management agencies cannot provide other services to waiver participants without the express permission of DOM. At no time are individual case managers authorized to provide direct care services. Oversight of waiver processes and periodic evaluations are completed by the DOM Office of Mental Health and Office of Financial & Performance Audit.

At enrollment, the person is informed by the Support Coordinator of the specific criteria and processes for a dispute, complaint/grievance and State Fair Hearing as outlined in Appendix F of this waiver. The person has the right to address any disputes regarding services with DOM at any time. The participant also signs a Bill of Rights outlining their rights and the appropriate contact information.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 1: Number and percent of persons reviewed whose PSS addresses all their needs (including health and safety risk factors and personal goals). N: Number of persons whose PSS is reviewed that addresses all their needs (including health and safety risk factors and personal goals). D: Total number of persons whose PSS was reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTSS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 2: Number and percent of persons' PSSs reviewed where the individual's signature indicates involvement in the PSS development. N: Number of persons' PSSs reviewed with signature indicating involvement in PSS development. D: Total number of PSS reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTSS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 3: Number and percent of persons reviewed whose quarterly face-to-face visits are performed according to the waiver application. N: Number of persons reviewed whose quarterly face-to-face visits are performed according to the waiver application. D: Total number of persons reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Financial and Performance Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every 24 months

Performance Measure:
PM 4: Number and percent of PSSs reviewed which are updated/revised annually and as warranted. N: Number of PSSs reviewed that are updated annually and as warranted. D: Total Number of PSSs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Support Coordination Monitoring Tool and Checklist; LTSS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 5: Number and percent of persons reported receiving services in accordance with the PSS in the type, scope, amount, duration, and frequency. N. Number of persons reported receiving services in accordance with the PSS in the type, scope, amount, duration, and frequency. D. Total number of persons reviewed who reported receiving services.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Financial and Performance Audits

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every 24 months

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 6: Number and percent of waiver participants whose records documented an opportunity was provided for choice of waiver services and freedom of choice of providers. N: Number of waiver participants whose records documented an opportunity was provided for choice of waiver services and freedom of choice of providers. D: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Financial and Performance Audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	Every 24 months

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

In any instance in which it is discovered that the person-centered service plan was not developed, reviewed/updated, or implemented in accordance with the procedures outlined in Appendix D of this waiver, DOM will hold a quality improvement strategy meeting with the MDMH within 30 days to examine if any changes need to be implemented systematically. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP). In instances in which a CAP is needed, the MDMH and/or provider will have 30 days to submit the written corrective action plan detailing the plan for remediation. Once DOM approves the submitted corrective action plan, the MDMH and/or provider will have 30 days to implement the approved CAP. DOM will conduct necessary follow up to determine the effectiveness of remediation actions.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

If, upon initial evaluation it is determined that a person does not meet LOC requirements, the person/legal guardian is sent a "Notice of Ineligibility for ICF/IID Level of Care" from the Diagnostic and Evaluation (D&E) Team within ten (10) days of the finding of ineligibility for ICF/IID Level of Care and, therefore, the Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver. This notice outlines the procedures and timeframes for appealing this decision to the Mississippi Department of Mental Health (MDMH)and/or the State, supporting documentation required for the appeal and to whom to send the information.

Fair Hearing procedures encompass the following adverse actions: (a) not providing an individual the choice of home and community-based services as an alternative to institutional care; (b) denying an individual the service(s) of their choice or the provider(s) of their choice; and, (c) actions to deny, suspend, reduce or terminate services.

With MDMH and/or DOM approval, a person may be terminated from waiver services for any of the following reasons: (1) The person or his/her legal representative request termination; (2) The person no longer meets program eligibility requirements; (3) The person refuses to accept services; (4) The person is not available for services after thirty days; (5) The person is in an environment that is hazardous to self or service providers; (6) The person and/or individuals in the person's home become abusive and/or belligerent including, but not limited to, sexual harassment, racial discrimination, threats.

State Fair Hearing procedures are based on the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100, Chapters 4-5, and Part 300, Chapter 1. Applicant is informed of Fair Hearing process during entrance to waiver by the Support Coordinator. A Support Coordinator sends a Notice of Action (NOA) to the person by mail on any adverse action related to choice of provider or service; or denial, reduction, suspension or termination of service. Fair Hearing Notices are maintained in person's file at the operating agency.

Contents of Notice of Action include:
a. Description of the action the operating agency has taken or intends to take;
b. Explanation for the action;
c. Notification that the person has the right to file an appeal;
d. Procedures for filing an appeal;
e. Notification of persons right to request a Fair Hearing;
f. Notice that the persons has the right to have benefits continued pending the resolution of the appeal; and
g. The specific regulations that support, or the change in Federal or State law that require, the action.

The person or their representative may request to present an appeal through a local level hearing, a state-level hearing, or both. In an attempt to resolve issues at the lowest level possible, offices should encourage persons to request a local hearing first. The request for a hearing must be made in writing by the person or his/her legal representative.

The person may be represented by anyone he/she designates. If the person elects to be represented by someone other than a legal representative, he/she must designate the person in writing. If a person, other than a legal representative, states that the person has designated him/her as the person's representative and the person has not provided written verification to this effect, written designation from the person regarding the designation must be obtained.

The person has 30 days from the date the appropriate notice is mailed to request either a local or state hearing. This 30-day filing period may be extended if the person can show good cause for not filing within 30 days.

A State Fair Hearing will not be scheduled until a written request is received by either the MDMH or DOM state office. If the written request is not received within the 30-day time period, services will be discontinued. If the request is not received in writing within 30 days, a hearing will not be scheduled unless good cause exists as identified in the Administrative Code.

At the local hearing level, the operating agency will issue a written determination within 30 days of the date of the initial request for a hearing. Although the waiver allows 30 days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

The person has the right to appeal a local hearing decision by requesting a State hearing; however, the State hearing request must be made within 15 days of the mailing date of the local hearing decision.

At the State hearing level, DOM will issue a determination within 90 days of the date of the initial request for a hearing. Although regulations allow 90 days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

The person or his/her representative has the following rights in connection with a local or state hearing:

1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or person's case record.
2. The right to have legal representation at the hearing and to bring witnesses.
3. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.
4. The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.

Services must remain in place during any appeal process unless the accommodations cannot be made for the safety or threat of harm of the person or service providers. Case management staff will notify person if services will remain in place during the appeal process. Upon receipt of the request for a state hearing, the DOM Office of Appeals will assign a hearing officer.

Fair Hearing notices are maintained in person's file at the support coordination agency.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

DOM and the operating agency are responsible for operating the grievance and complaint system. DOM has the final authority over any complaint or grievance.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

People receiving supports, family members, caregivers, or other interested parties have multiple avenues for filing a grievance. Grievances are received by phone, written format, or email. Upon receipt of a grievance, a Consumer Advocate within the MDMH Office of Consumer Support (OCS) categorizes the grievance based on an established level system. When a person elects to file a grievance, they are informed that doing so is not a pre-requisite or substitute for a Fair Hearing.

Level I grievances are areas of concern related to a person's issues including, but not limited to: inappropriate services or level of service, provider non-compliance with issues related to the Plan of Services and Supports, Support Coordination, etc. Level I grievances are typically resolved with an explanation of policy, regulation or standard. Level I grievances may also include a referral to other services and/or supports.

Level II grievances are areas of concern of a more serious nature such as a possible serious incident, violation of rights, denial of services, insufficient care to ensure a person's health and welfare, etc. Level II grievances require MDMH inquiry to support or disprove an area of concern. MDMH inquiry includes requests for information related to the grievance and can also include an on-site visit to obtain information and/or interview staff.

Level III grievances are areas of concern of the most serious nature, such as suspected abuse/neglect/exploitation, egregious violation of rights including seclusion/restraint, violations of Final Rule requirements regarding modifications to HCBS settings, etc., mistreatment of a person and/or denial of services. Level III grievances require MDMH inquiry to support or disprove a grievance. MDMH inquiry includes requests for information related to the grievance and can also include an on-site visit to obtain information and/or interview staff.

All grievances must be resolved within 30 days of OCS receipt. The person filing the grievance is provided formal notification from the Director of OCS of the resolution and activities performed in order to reach the resolution of the grievance.

The grievance process includes an opportunity for the person to request reconsideration should he/she not be satisfied with the resolution. The person filing the grievance can request reconsideration from the Deputy Director of the MDMH. The individual will be formally notified in writing of the decision related to the reconsideration. Should the person originally filing the grievance not be satisfied with the reconsideration decision, he/she can appeal to the Executive Director of the MDMH. The Executive Director will formally notify the person of his/her decision. All decisions of the MDMH Executive Director are final.

The mechanisms used to resolve grievance/complaints include, but are not limited to: individual interviews, staff interviews, record review, phone inquiry, and on-site investigation.

State Fair Hearing procedures and processes will comply with the requirements as established in the Mississippi Division of Medicaid Administrative Code, Title 23, Part 100, Chapters 4-5, and Part 300, Chapter 1. Participants are advised that at no time will the informal dispute resolution process conflict with their right to a Fair Hearing in accordance with Fair Hearing procedures and processes.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Mississippi Code § 43-47-7 identifies a comprehensive list of mandatory reporters of suspected abuse, neglect or exploitation and required reporting timeframes. This code is available at https://law.justia.com/codes/mississippi/2010/title-43/47/43-47-9/.

Critical incidents are identified as follows:

Abuse (A) - willful or non-accidental infliction of a single or more incidents of physical pain, injury, mental anguish, unreasonable confinement, willful deprivation of services necessary to maintain mental and physical health, and sexual abuse.

Neglect (N) - can include but is not limited to a single incident of the inability of a vulnerable person living alone to provide for himself, failure of a caretaker to provide what a reasonably prudent person would do.

Exploitation (E) - Illegal or improper use of a vulnerable person or his resources for another's profit or advantage with or without the consent of the vulnerable person. This can include acts committed pursuant to a power of attorney and can include but is not limited to a single incident.

The Department of Human Services (DHS), Division of Aging and Adult Services, is the agency responsible for investigating allegations of A, N and E in accordance with Mississippi Code § 43-47-9. All reports of A, N and E must be reported immediately by the appropriate Support Coordinator to their supervisor and the Department of Human Services. The potential incidents are also to be reported in writing to the DOM as it occurs. If the waiver participant is at risk for harm or injury related to an unsafe environment, the Support Coordinator calls 911 to request immediate assistance.

There is a memorandum of understanding (MOU) established between DOM and DHS which allows for a free flow of information regarding critical incidents between the two agencies to ensure the health and welfare of waiver participants. DOM and the operating agency follow up with DHS to ensure that reports are investigated, and action is taken. In cases of Vulnerable Adult Abuse, reports may also be submitted to the Mississippi Attorney General's Office.

The process ensures an individual’s rights to privacy, dignity, respect, and freedom from coercion and restraint.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Upon admission and at least annually thereafter, every service provider is required to provide people receiving services and/or their legal guardians, both orally and in writing, the MDMH's and program's procedures for protecting people receiving services from abuse, exploitation, and neglect. Each person/legal guardian is provided a written copy of his/her rights. Program staff reviews the rights with each person/legal guardian and the person/legal guardian signs the form indicating the rights have been presented to them both orally and in writing, in a way which is understandable to them. Contained in the rights is information about how the individual/legal representative can report any suspected violation of rights and/or grievances, to the MDMH Office of Consumer Support and the State's Protection and Advocacy agency, Disability Rights Mississippi. The toll-free numbers are posted in prominent places throughout each day program site.

The person is contacted by the Support Coordinator(s) on a monthly basis (by phone or face-to face visit). If there is a concern regarding abuse, neglect, exploitation, and the person and/or person's representative has notified the Support Coordinator of their concern by phone, a home visit may be conducted. The purpose of the home visit is to assess the situation, document an account of the occurrences, and notify the proper authorities. MDMH and DOM are notified of any suspected abuse, neglect, exploitation cases as they occur, and is available to provider support in ensuring a prompt resolution, if feasible.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

MDMH's Office of Incident Management, as the lead agency responsible for incident reporting requirements, maintenance of MDMH's Incident Management Information System, and investigations of reported incidents, is responsible for the notification of investigation results to parties as designated by state law (Attorney General's office, Department of Human Services, Child Protective Services, Local Authorities, etc.). Notification is made to the participant's family or legal representative, the waiver provider, applicable licensing and regulatory authorities, and the State within 30 days of the end of the investigation by MDMH.

Incidents may be reported via telephone with subsequent written documentation received via email or fax. In addition to reporting to MDMH, incidents of suspected abuse/neglect/exploitation must be reported to the MS Department of Human Services and/or the Office of the Attorney General, dependent upon the type of event.

Serious incidents to be reported within twenty-four (24) hours include, but are not limited to:

1. Suicide attempts on provider property or at a provider-sponsored event;
2. Unexplained or unanticipated absence from any MDMH certified program for any length of time;
3. Incidents involving injury of a person receiving services while on provider property or at a provider- sponsored event, or
   being transported by a MDMH certified provider;
4. Emergency hospitalization or treatment while receiving services;
5. Medication errors;
6. Accidents which require hospitalization that may be related to abuse/neglect/exploitation, or in which the cause is unknown
   or unusual;
7. Disasters such as fires, floods, tornadoes, hurricanes, snow/ice events, etc.
8. Use of seclusion or restraint that is not part of a person's Plan of Services and Supports, Crisis Intervention Plan, or Behavior Support Plan.

Serious incidents to be reported verbally within eight (8) hours, to be followed by the written Serious Incident Report within twenty-four (24) hours, include:

1. Death of an individual on provider property, participating in a provider-sponsored event, or during the provision of any
   service
2. Unexplained absences from any MDMH certified program;
3. Suspicions of abuse/neglect/exploitation of a person receiving services while on provider property, at a program sponsored
   event.

Upon receipt of a Serious Incident, whether it comes in as a self-report from a certified program or as a grievance/complaint, the incident is categorized based on an established level system.

Level I incidents are areas of concern related to a person's issues including, but not limited to: inappropriate services or level of service, provider non-compliance with issues related to the Plan of Services and Supports, Support Coordination, etc. Level I grievances are typically resolved with an explanation of policy, regulation or standard. Level I grievances may also include a referral to other services and/or supports. Level I self-reported incidents are reviewed to ensure that all appropriate actions have been taken including identification of possible contributing factors, that implementation of follow up actions to mitigate or prevent the event from occurring again have been put in place, that all mandatory reporting required by law has been completed, and any applicable disciplinary actions have been administered.

Level II incidents are areas of concern of a more serious nature such as violation of rights, denial of services, insufficient care to ensure a person's health and welfare, etc. Level II grievances require MDMH inquiry to support or disprove an area of concern. For both Level II self-reported incidents and grievances MDMH inquiry includes requests for information related to the event and can also include an on-site visit to obtain information and/or interview staff.

Level III incidents are areas of concern of the most serious nature, such as suspected abuse/neglect/exploitation, egregious violation of rights including seclusion/restraint, violations of Final Rule requirements regarding modifications to HCBS settings, etc., mistreatment of a person and/or denial of services. Level III grievances require MDMH inquiry to

support or disprove the grievance. For both Level III self-reported incidents and grievances MDMH inquiry includes requests for information related to the grievance and can also include an on-site visit to obtain information and/or interview staff.

An inquiry into self-reported incidents or those reported through the grievance/complaint system is conducted within thirty (30) days. MDMH inquiry includes requests for information related to the event and can also include an on-site visit to obtain information and/or interview staff. MDMH Operational Standards require certified providers to participate with this process. Based on the submission of requested information or the conclusion of an on-site visit, should corrective action be required, MDMH issues a report of findings based on the incident. That report of findings must be addressed by the provider within thirty (30) days. All grievances must be resolved within 30 days of receipt. The person filing the grievance is provided notification from the Director of the Office of Consumer Support of the activities performed in order to reach the resolution of the grievance.

Mississippi Code § 43-47-7 identifies a comprehensive list of mandatory reporters of suspected abuse, neglect or exploitation and required reporting timeframes. This code is available at https://law.justia.com/codes/mississippi/2010/title-43/47/43-47-9/.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

MDMH is responsible for overseeing the reporting and follow up to serious incidents that affect people enrolled in the waiver. Oversight is conducted on an ongoing basis through the process outlined in b-d above. As the operating agency for the waiver, MDMH provides DOM quarterly summary reports regarding serious incidents related to people enrolled. DOM will review the report summary and analyze on an individual basis to determine if the appropriate plan of action was taken. This information will be used to develop quality improvement measures to address any issues identified.

All MDMH Certified Providers are required to report critical incidents as outlined in Chapter 15 of the MDMH Operational Standards. Providers should report any incident they feel is important, even if it is not mentioned in the standards. Incidents must be reported in writing within 24 hours of the incident. Death of an individual must be reported verbally to the MDMH Office of Consumer Support Incident Management within eight (8) hours to be followed by a written report within 24 hours. Providers may report these incidents via email, fax, or in a few cases traditional hard copy mail, although fax or email is preferred.

The MDMH Director of Incident Management and the Director of the Bureau of Intellectual and Developmental Disabilities review all incidents as they are received. If additional information is needed, a request to the provider is made via phone or email, or in some cases an onsite investigation is scheduled. In cases of abuse, neglect and/or exploitation, MDMH reports to the Attorney General. Following investigative finding, these are given to MDMH's Division of Certification who will issue an official request for any plans of compliance (POCs) needed. Any other action that is necessary, such as suspension of a certification also comes from the Division of Certification.

All data from the report is entered into an Access Database and the electronic files are attached to the entry for each incident. Data elements include a narrative summary and disposition of the incident, date of incident, provider, place of the incident, service(s) being provided, person(s) involved, event category, status, triage level, disposition, agencies reported to, and any additional comments. This data can be searched or filtered by any one of the elements or by any combination of the elements and can be compared to previous time periods to identify trends. Reports are run quarterly, or as needed, based on any desired combination of data elements. Identified trends are then communicated to the providers and MDMH works with providers to develop improvement strategies to prevent future occurrences of the same type of incident(s).

The DHS Division of Aging and Adult Services, which administers protective services, is responsible for investigations of critical incidents as outlined in G-1-b. Under the Interagency Agreement with DHS, both entities meet to discuss the process and any trends identified.

The overall system is monitored continuously as a component of QIS as outlined in Appendix H.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The State prohibits the use of restraints during the course of the delivery of waiver services. MDMH is responsible for ensuring that restraints are not used for waiver participants. All providers are required to receive training in methods to detect abuse, neglect and exploitation which includes unauthorized use of restraints, restrictive interventions, and seclusion.

The Support Coordinator(s) is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. Incidents of restraints are immediately reported verbally and in writing by the Support Coordinator to their supervisor. The Mississippi Attorney General's Office is also contacted to report allegations of Vulnerable Adult Abuse. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

The MDMH, through on-site monitoring and Serious Incident Reporting tracks whether restraints are used.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The State prohibits the use of restrictive interventions during the course of the delivery of waiver services. MDMH is responsible for ensuring that restrictive interventions are not used for waiver participants. All providers are required to receive training in methods to detect abuse, neglect and exploitation which includes unauthorized use of restraints, restrictive interventions, and seclusion. The Support Coordinator(s) is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. Incidents of restrictive interventions are immediately reported verbally and in writing by the Support Coordinator to their supervisor. The Mississippi Attorney General's Office is also contacted to report allegations of Vulnerable Adult Abuse. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

The MDMH, through on-site monitoring and Serious Incident Reporting tracks whether restrictive interventions are used.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State prohibits the use of seclusion during the course of the delivery of waiver services. MDMH is responsible for ensuring that seclusion is not used for waiver participants. All providers are required to receive training in methods to detect abuse, neglect and exploitation which includes unauthorized use of restraints, restrictive interventions, and seclusion.

The Support Coordinator(s) is responsible for monthly contact with waiver persons to ensure safety and the quality of waiver services provided. Incidents of seclusion are immediately reported verbally and in writing by the Support Coordinator to their supervisor. The Mississippi Attorney General's Office is also contacted to report allegations of Vulnerable Adult Abuse. The process ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint.

The MDMH, through on-site monitoring and Serious Incident Reporting tracks whether seclusion is used.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The MDMH is responsible for oversight of medication management through certification reviews. Monitoring is conducted during annual reviews, investigation of complaints, or notification of critical incidents involving medication errors as warranted.

The medical responsibility for people enrolled in Supervised Living, Supported Living, Shared Supported Living is vested in a community licensed physician of their choice. Each Supervised Living, Supported Living, and Shared Supported Living provider must employ appropriately trained or professionally qualified staff to administer medications if a person requiring medication cannot administer to him or herself. All waiver service providers employing staff who administer medications to people receiving services have daily and ongoing responsibility for medication monitoring to ensure that medications are correctly administered, and that medication administration is appropriately documented in accordance with State requirements. Providers must have written policies and procedures for medication administration and implementation of such policies is evaluated during MDMH certification reviews.

First line responsibility for monitoring a person's medication regimen resides with the medical professionals who prescribe the medication(s). Second line monitoring is provided by the staff in the Supervised Living, Supported Living or Shared Supported Living setting. Staff monitoring focuses on areas identified by the physician and /or pharmacist which may be of concern. If a person is using a behavior modifying medication (psychotropic medication), the State program nurse will determine whether (1) there is documentation of voluntary, informed consent for the use of the medication; and (2) the person or his/her family member or guardian/conservator was provided information about the risks and benefits of the medication. Staff observations regarding the behavior which the medication has been prescribed to reduce are reported to the provider. Each waiver provider must have policies and procedures that identify the frequency of monitoring. People receiving services have a choice of physicians and pharmacies, but are encouraged to be consistent in their use of these professionals in order to ensure continuity of care and to prevent the possibility of a physician unknowingly prescribing a medication which may be contraindicated with another medication prescribed.

Additionally, the State makes available a provider portal called Provider Access so that prescribing physicians and other providers can view the medical and pharmacy histories of Medicaid beneficiaries.

After each doctor’s visit, and with the individual’s consent, Supervised Living, Supported Living, Shared Supported Living staff document the reason for the visit, the physician’s instructions, including monitoring for any potential unwanted side effects of prescribed medication(s). Documentation regarding visits to physicians is reviewed by all staff and the review is documented via their initials on the form.

All treatment shall be provided by, or provided under the direction or supervision, of professionally qualified staff. Medication is reviewed by appropriately qualified staff. Appropriately qualified staff includes physicians, physician assistants, and advanced registered nurse practitioners acting with the scope of their professional licensure.

The State specifies the treating physician shall perform any physiological testing or other evaluation(s) necessary to monitor the person for adverse reactions, or other health related issues which might arise in conjunction with taking medication, including prescribed psychotropic medications.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The State specifies the treating physician shall perform any physiological testing or other evaluation(s) necessary to monitor the individual for adverse reactions or other health related issues which might arise in conjunction with taking medication, including prescribed psychotropic medications.

The MDMH is responsible for oversight of medication management and employs licensed nurses who makes annual reviews of Supervised Living, Supported Living and Shared Supported Living providers to ensure they are following required procedures regarding the medication regimen of people who require such. During annual certification reviews, the State reviews the person's Medication Administration Record (MAR) to identify potentially harmful practices and to ensure compliance with documentation requirements. During annual certification reviews, the program nurse reviews a sample of service recipient Medication Administration Records to identify potentially harmful practices and to ensure compliance with medication administration documentation requirements. Medication error reports are also reviewed. Provider medication management policies and practices are reviewed to ensure that:

a. The Medication Administration Record correctly lists all medications taken by each person;
b. The Medication Administration Record is updated, signed, and maintained in compliance with the State medication administration
documentation requirements;
c. All medications are administered in accordance with physician’s orders;
d. Medications are administered by appropriately trained staff;
e. Medications are kept separated for each person and are stored safely, securely, and under appropriate environmental conditions.

Providers are required to complete a reportable incident form for medication errors. If the medication error caused, or is likely to cause, harm, the provider must submit a copy of the Reportable Incident Form to the MDMH. The MDMH receives and reviews the reportable incident forms for completeness and determination of the nature of the incident and monitors for medication error trends utilizing data from the Incident and Investigations database. Personnel Records are reviewed to ensure that staff who administers medications are appropriately licensed. When the certification review team identifies potentially harmful medication administration/management practices, the team notifies the provider during the review, and then reviews such issues during the exit conference at the end of the review. In addition, the provider is notified in writing of any problems identified during the review. The CAP must be received by the MDMH no later than thirty (30) working days from the Written Report of Findings following the ID/DD Waiver provider’s receipt of its status ruling.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

MDMH requires that the administration of all prescription drugs must be directed and supervised by a licensed physician or licensed nurse in accordance with the MS Nursing Practice Law. Practices for the self-administration of medication by people receiving services are developed in consultation with the medical staff of the provider or the person's treating medical provider(s). Non-medical waiver providers cannot administer or oversee the administration of medications.

Medication Assistance is any form of delivering medication which has been prescribed which is not defined as "medication administration", including, but not limited to, the physical act of handing an oral prescription medication to the patient along with liquids to assist the patient in swallowing. Non-licensed staff proving medication assistance must complete required "Assistance with Medication" training and demonstrate skills with registered nurse at hire and annually thereafter prior to assisting individuals with medication. Administration of medications must be conducted by licensed nurse in accordance with MS Nursing Practice Law, Rule 13.8.C. of DMH Operational Standards (https://www.dmh.ms.gov/wp-content/uploads/2022/05/Revised-DMH-2020-Operational-Standards-5-19-22-1.pdf).

Nursing activities must comply with Mississippi Board of Nursing Administrative Code, Part 2830.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

All medication errors shall be reported to the MDMH Office of Incident Management, the State, and appropriate licensure boards. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing in accordance with the Mississippi Board of Nursing Administrative Code.

(b) Specify the types of medication errors that providers are required to *record:*

All medication errors shall be reported to MDMH Office of Incident Management, the State, and appropriate licensure boards and by the next working day after the occurrence.

(c) Specify the types of medication errors that providers must *report* to the state:

All medication errors shall be reported to MDMH Office of Incident Management, the State, and appropriate licensure boards and by the next working day after the occurrence. Additionally, if the medication error is made by a licensed nurse, the report must be made to the Mississippi Board of Nursing in accordance with the Mississippi Board of Nursing Administrative Code.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The MDMH communicates information and findings regularly to the Division of Medicaid following certification visits which includes an evaluation of medication administration. MDMH provides DOM with a copy of the provider's current certification verifying the facility is in compliance with the MDMH Operational Standards. In the event the facility is out of compliance at the annual survey or in the event of a complaint investigation or unscheduled visit, the MDMH provides DOM with copies of cited deficiencies.

The State with MDMH identifies trends and patterns through annual data analysis. After the data is analyzed, the information is synthesized to determine if improvement strategies need to be implemented across this waiver as well as the possibility of a more global approach across all of the State waivers.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 1: Number and percent of all critical incidents that were reported or remediated in accordance with waiver policy. N: Number of all critical incidents that were reported or remediated in accordance with waiver policy. D: Total number of critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Tracking Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
PM 2: Number and percent of persons reviewed whose emergency preparedness plan (EPP) in the Plan of Services and Supports (PSS) address prevention strategies for identified risks. N: Number of persons reviewed whose EPP in the PSS address prevention strategies for identified risks. D: Number of persons reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTSS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM 3: Number and percent of persons who receive information on how to report suspected cases of abuse, neglect, or exploitation. N: Number of persons reviewed who received information on how to report suspected cases of abuse, neglect, or exploitation. D: Total number of person's records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTSS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 4: Number and percent of complaints that were addressed/resolved as approved in the waiver. N: Number of complaints that were addressed/resolved as approved in the waiver. D: Total number of complaints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Tracking Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM 5: Number and percent of annual complaint reviews completed where themes are identified and training was provided to prevent further similar incidents to the extent possible. N: Number of annual complaint reviews completed where themes are identified and training was provided to prevent further similar incidents to the extent possible D: Total number of annual complaint reviews.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Tracking Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 6: Number and percent of participants for which state policies regarding the prohibition of the use of restrictive interventions (including restraints and seclusion) were followed. N: Number of participants for which state policies regarding the prohibition of the use of restrictive interventions (including restraints and seclusion) were followed. D: Total number of unduplicated participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Tracking Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 7: Number and percent of participants whose records document a medical examination at least every 3 years in accordance with state requirements. N: Number of participants whose records document a medical examination at least every 3 years in accordance with state requirements. D: Total number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTSS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

In any instance in which it is discovered that the critical incident management or complaint system systems or the participant safeguard monitoring processes are not implemented in accordance with the procedures outlined in Appendix G of this waiver, DOM will hold a quality improvement strategy meeting with the MDMH within 30 days to examine if any changes need to be implemented systematically. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP). In instances in which a CAP is needed, the MDMH and/or provider will have 30 days to submit the written corrective action plan detailing the plan for remediation. Once DOM approves the submitted corrective action plan, the MDMH and/or provider will have 30 days to implement the approved CAP. DOM will conduct necessary follow up to determine the effectiveness of remediation actions.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Division of Medicaid has staff designated to assist in system design. Meetings are held routinely, as needed, to develop system change requests, review progress, and test system changes. The meetings involve participation for the DOM Office of Technology (iTech) and Long-Term Services and Supports (LTSS), along with any other stakeholders deemed appropriate depending on the issue for discussion. Meetings with LTSS staff, including DOM and operating agency staff are held routinely for the purpose of addressing needs and resolving issues that may involve system changes.

The state utilizes system generated reports, post-payment audits, and quality interviews to identify trends in policy non-compliance, grievance and critical incident reporting, and improper billing. Once trends are identified, the state reviews findings in the QIS meetings to evaluate opportunities for resolution including additional training, system upgrades, changes in policy, etc. Resolutions to quality issues identified through QIS monitoring are shared with stakeholders through public notice on policy change as well as provider education and notices.

When the state identifies a system issue, it is reported to the fiscal agent for review and research. System issues that affect services to participants or affect accurate payment to providers are considered a priority. The State holds monthly meetings with the program staff to address issues that require system changes. Additionally, the State has monthly internal Advisory meetings to identify, correct, and implement system changes to improve the State's ability to adhere to state and federal regulation, policies, and procedures. System changes have been implemented to allow for electronically capturing data and identifying trends related to the performance measures. Findings are discussed during collaborative Qualify Improvement Strategy meetings with the operating agency and DOM. Reporting information form the eLTSS case management system is also utilized in quality improvement strategies as a source of reporting data for multiple qualify measures.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: Ongoing and as needed.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Division of Medicaid (DOM) and the operating agency monitor the quality improvement strategy on a quarterly basis. Annual reviews are also conducted and consist of analyzing aggregated reports and progress toward meeting one hundred (100) percent of sub assurances, resolution of individual and systemic issues found during discovery, and notating desired outcomes. When change in the quality improvement strategy is necessary, a collaborative effort between DOM and the operating agency is made to meet waiver reporting requirements.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Evaluation of the quality improvement strategy is a continuous and ongoing endeavor. It is reviewed annually to determine if the participants are receiving the highest quality of care possible in the most effective and efficient means possible. The operating agency and DOM will meet quarterly to review the overall waiver operation including the QIS strategy for waiver improvement.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Pursuant to 2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards Subpart F – Audit Requirements §200.502 (i), Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis. DOM, therefore, does not require an independent audit of waiver service providers.

The Mississippi Office of the State Auditor is responsible for annual audits in compliance with the provisions of the Single Audit Act.

Claims for all waiver services are submitted to the Division's fiscal agent for reimbursement. Claims data is maintained through the Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits before payment.

The Mississippi Division of Medicaid operates three audit units within the Office of Compliance to assure provider integrity and proper payment for Medicaid services rendered. The Office of Program Integrity investigates any suspicion of fraud or abuse reported or identified. They also review payment records of Medicaid providers continually and on an ongoing basis. The Office of Financial and Performance Audit conducts routine monitoring of cost reports and contracts with other agencies as well as waiver provider specific audits. The Office of Compliance audits coordinated care organizations, state agencies, and other entities as necessary to ensure program compliance. In all audit units, staff set audit priorities each year based upon established criteria.

Annual waiver audits are completed by the DOM Office of Financial and Performance Audit. In addition to auditing a sample of financial claims, within that sample, each performance measure for the waiver will be tested using the claims sample. The audit time frame will be one, prior 12-month period for providers within the waiver program. For each audit, DOM will use a representative sampling methodology that ensures a 95% confidence level with a +/- 5% error rate. Each waiver provider type will be risk assessed using a three-year prior trend. Based on the percentage of errors, deficiencies, and problems, a risk score will be assigned. If it is determined that certain provider types have a higher risk of issues, errors, etc., then the samples will be determined by service type. Otherwise, the sample will be based on the entire provider population within that waiver. If the entire population is used, DOM will ensure that all provider types are included in the sample. If system edits are in place to prevent payment to a provider type without required/verified credentials (e.g. edits that prevent claims payment to providers with expired/revoked licenses), those provider types may be excluded from the sample for associated metrics.

Should annual waiver audits indicate a fraud issue, then the provider will be referred to the DOM Office of Program Integrity for further investigation. Any estimate of overpayment within Program Integrity is made utilizing a simple extrapolation with a standard error of the estimated overpayment and the confidence interval estimate of the total overpayment calculated from the data obtained from the sampled line items. The estimate of total overpayment is obtained by calculating the overpayment for each stratum and summing these overall strata.

Post-payment audits of all waiver services can be conducted through a medical record request desk audit or as an on-site review. The on-site audit can be announced or unannounced, based upon the circumstances behind the audit recommendation. Depending on multiple factors, risk assessments typically result in one of the following recommended actions (dependent upon the severity of the allegations and other information uncovered during the risk assessment):

• No further action – No issues uncovered warranting further action.

• Provider education – No major issues identified that would result in patient harm or overpayments; however, it may be apparent that the provider as well as the Medicaid Program would benefit from additional education for the provider on proper/best billing practices.

• Provider desk audit – Concern(s) were identified resulting in the need for medical record review (could be full or limited scope). However, the severity of the concerns does not currently warrant an on-site review. Certain provider records, including medical records, are requested for selected claims and clinical staff (if necessary) conduct a review of the services billed to ensure compliance with DOM guidelines. Providers are allowed thirty (30) days to submit the requested information.

• Provider on-site audit (announced or unannounced) – Severity of the concern(s) has resulted in a recommendation of an on-site audit or where electronic records are not available from providers. Providers are generally given shorter notice (or no notice if warranted) of the pending on-site audit. If notice is provided, it can range from a few days to a few of weeks

depending on several factors (i.e., type of facility, audit concerns, etc.). Requested information is collected on-site. A facility tour as well as provider/staff interviews are also conducted during on-site reviews. DOM staff, including clinical staff if appropriate, are included in on-site reviews and assist with conducting interviews.

• Referral to MFCU – Payment suspension recommended as the potential intent of fraudulent behavior was identified. Depending on the allegations/information received regarding the provider(s), the SUR Unit may conduct a Preliminary Investigation to determine the appropriate next steps, if any.

Audit reports/management letters provide detailed information on identified deficiencies, including but not limited to, accuracy-related issues, missing documentation, internal control deficiencies, and training issues and are presented to the provider at the end of the audit. Providers are allowed 30 days to submit comments, questions, or corrective action plans. After the comment period, a final findings letter/demand letter is issued that identifies overpayments that must be repaid. In response to the demand letter, the provider is required to repay within 30 days. If a repayment agreement is not submitted, either a recoupment is made by DOM through the fiscal agent or the provider requests an extended repayment schedule, which must be followed by the provider. Any overpayments are set up for recoupment. Audit reports are distributed to provider administrators and appropriate staff at DOM and the operating agency.

Once the time for a provider to appeal any findings for recoupment have passed, if a provider has not completed manual adjustment based on the findings in the report, a request for a credit balance entry for the recoupment amount is sent to our Fiscal Agent. The recoupment may be made at 100% of the provider's claims payments until the full amount is recouped. If requested by the provider and deemed feasible by DOM leadership, the weekly recoupment amount may be reduced to allow some payment to the provider. However, over the approved period, the full credit balance is recouped and verified.

As claims are adjusted or if a recoupment through a credit balance entry is made, the claims payment for this category on the CMS-64 is adjusted if it is the current quarter or the amount recouped is included on the CMS-64 as a prior period adjustment for the period of the claims payment(s).

Home and Community Supports, In Home Respite services, In Home Nursing Respite services, and Supported Living are subject to electronic visit verification in accordance with the MS Medicaid Administrative Code. Methods for verification include GPS enabled mobile application or integrated voice recognitions (IVR) utilizing the participant's telephone or a fixed object device. Once the state's upgraded EVV solution is implemented in Summer/Fall 2023, a claims edit will be implemented to ensure claims flow appropriately from the EVV system to ensure financial integrity and accountability.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 1: Number and percent of claims paid in accordance with the reimbursement methodology specified in the approved waiver. N: Number of claims coded and paid correctly in accordance with the reimbursement methodology specified in the approved waiver. D: Total number of claims paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS System/Cognos

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
PM 2: Number and percent of waiver service claims reviewed that were submitted for services within the persons' PSS. N: Number of waiver service claims reviewed that were submitted for services within the persons' PSS. D: Total number of service claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Financial and Performance Audit

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other***	☒ ***Annually***	☐ ***Stratified***

Specify:		*Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Every 24 months*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PM 3: Number and percent of provider payment rates that are consistent with rate methodology in the approved waiver application or subsequent amendment. N: Number and percent of provider payment rates that are consistent with rate methodology in approved waiver application or subsequent amendment. D: Total number of payments.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

In any instance in which it is discovered that financial accountability activities are not implemented in accordance with the policies/procedures outlined in Appendix I of this waiver, DOM will hold a quality improvement strategy meeting with the MDMH within 30 days to examine if any changes need to be implemented systematically. In some cases, informal actions, such as obtaining an explanation of the circumstances surrounding the event, or verification that remediation actions have been taken, may be sufficient to deem the problem resolved. In other situations, more formal actions may be taken. This may consist of a written corrective action plan (CAP). In instances in which a CAP is needed, the MDMH and/or provider will have 30 days to submit the written corrective action plan detailing the plan for remediation. Once DOM approves the submitted corrective action plan, the MDMH and/or provider will have 30 days to implement the approved CAP. DOM will conduct necessary follow up to determine the effectiveness of remediation actions. DOM will report intentional submission of erroneous claims to DOM Division of Program Integrity for follow up within 48 hours of discovery and recoup money paid erroneously to providers.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☒ ***Monthly***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

As of the submission of this renewal, the state has a comprehensive workforce/provider survey and corresponding rate study underway. DOM has contracted with an actuary firm to thoroughly evaluate and rebase service rates. As those studies were not completed by the CMS submission deadline, DOM worked with our actuarial firm to update the existing rates established using the historical methodology outlined below in order to increase reimbursement to reflect economic changes since the last time each fee was reviewed. This update was completed by adjusting the direct practitioner costs based on Mississippi specific Bureau of Labor Statistics (BLS) wage data from May 2021 and then trending forward the rates utilizing the Medicare Economic Index (MEI) from Quarter 2 2021 to the Quarter 3 2023 forecast. The 4.4% average projected MEI was applied annually to the SFY 2022 CMS 372 report data to develop the WY1 (SFY 2024) estimates. Once the comprehensive studies are completed, DOM will submit waiver amendments to further update rates/methodologies where appropriate.

Due to the ongoing rate study, no rate methodologies were updated other than as described in the above paragraph. DOM, with input from their actuarial contractors, are responsible for rate determination. None of the service rates vary geographically. Due to the relatively small, rural nature of the state, variance in provider costs are minimal across the coverage area and statewide Mississippi specific Bureau of Labor Statistics data is utilized to inform assumptions related to wages.

Rates are reviewed annually to ensure are consistent with economy, efficiency, and quality of care and are sufficient to enlist enough providers. This process includes the review of feedback from various stakeholders, comparison to similar state plan services, and a review of utilization trends. The rate methodology utilized is reviewed at a minimum every 5 years prior to waiver renewal to ensure assumptions continue to align with services definitions and provider requirements. Information about payment rates is made available to waiver participants via the DOM website and rates are also included in person-centered Plans of Services and Supports. Additionally, rate determination methods outlined in this appendix were posted for public input with the renewal application as outlined in Main, Section 6-I of this application.

Historical Rate Methodology
Both DMH and the Division of Medicaid are responsible for rate setting and oversight. The rate models were the same as the ones revised in October 2015 that were submitted in the ID/DD Waiver Amendment with an effective date of 5/1/17 Providers have indicated to DMH that the rates have improved their ability to provide more assistance to people receiving services, thus allowing them additional staff to adequately meet the Final Rule requirements for community access and choice.

Burns & Associates reviewed the rate models in the fall of 2017 and calculated what the rate would be using up-to-date information from published data sources for wages, benefits, and mileage costs and making minor methodological refinements. Burns & Associates found that, for nearly every service, the updated calculations were within plus or minus three percent of the current rate. Based upon these results, no changes were made to the October 2015 rates DMH engaged Burns & Associates, Inc., a national consultant experienced in developing provider reimbursement rates to establish independent rate models that are intended to reflect the costs that providers face in delivering a given service. Specific assumptions are made for each of the category of costs outlined below. These assumptions, however, are not prescriptive and providers have the flexibility within the total rate to design programs that meet people's needs consistent with service requirements and each person's individual support plan. Both DMH and the State participated in the rate study conducted in 2014. The Memorandum of Understanding between the State and DMH states that rate adjustments can be made as agreed upon by DMH and the State.
The rate-setting process for each service included:
• Conducting a series of focus groups with providers for each category of services (for example, there was a series of groups for residential habilitation providers, for case management providers, etc.)
• Inviting all providers to complete a survey related to their service design and costs
• Identification of benchmark data, including Bureau of Labor Statistics cross-industry wage and benefit data as well as rates for comparable services in other CMS Region 4 states
• Development of rate models that include the specific assumptions related to the cost of delivering each service, including direct care worker wages, benefits, and 'productivity' (i.e., billable time); staffing ratios; mileage; facility expenses; and agency program support and administration
• Incorporating Inventory for Client and Agency Planning assessment data to create 'tiered' rates for residential and day habilitation services to recognize the need for more intensive staffing for individuals with more significant needs
• Emailing proposed rate models and supporting documentation, inviting the parties to submit comments, preparing

written responses to all comments received, and revising the rates based on these comments.

Rate models were developed for all waiver services with a few exceptions. Rates for Crisis Support and Nursing Respite were maintained at previous levels, based on an earlier rate study. Therapy services and medical supplies rates are aligned with the rates paid for those services in other Medicaid programs. Transition services are reimbursed based on actual costs.

The rates are the same for all providers. There are no variations based on provider type. On February 5-6, 2014, the process for the proposed rate determination method was presented to providers of all services as well as advocacy organizations. Interested parties were given one month to submit comments to a dedicated email account. Department of Mental Health considered these comments and compiled a comprehensive document detailing responses. Comments were considered and appropriately incorporated in the rate methodology. The rates revised in 2017 were available for public comment during the required 30-day comment period for the renewal.

Once service rates were calculated, a comparison was made of them to the current service rates along with consideration for other aspects of the service provision environment. DOM solicited public comments on the rates through stakeholder meetings, public notices, and notification to the tribal government.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Billings for all waiver services flow directly from providers to the State's claims payments system (MMIS). For services requiring electronic visit verification (In Home Nursing Respite, Home and Community Supports, In Home Respite and Supported Living), following the upgrade of the EVV system in Summer/Fall 2023, claims will be initiated in the EVV system and submitted to the fiscal agent via 837 transactions.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Billing validation is accomplished primarily by the Division's Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits prior to payment. DOM may subsequently validate billings post-payment in accordance with the audit strategy outlined in I-2-a. Recovery action is undertaken by the Division for any identified overpayments and the federal share of identified overpayments is returned to the Federal Government. Post-payment audits are structured to ensure that there is sufficient documentation that services were rendered.

The Mississippi Eligibility Determination System (MEDS) is a unified system for data collection and eligibility determinations. Electronic files from MEDS are loaded daily into the MMIS in order to ensure updated verification of eligibility for dates of service claimed. The first edit in the MMIS when a claim is filed ensures that the member is eligible for Medicaid services. Subsequent MMIS edits verify that the member has a valid waiver specific lock-in span that is entered on the member's MMIS record upon approval and recertification. Claims submitted for members who are not eligible on the date of service are denied.

All waiver services included in the participant's service plan must be prior approved by DOM. Approved Plans of Services and Supports (PSSs) are electronically tracked in the DOM electronic Long Term Services and Supports System (eLTSS).

In Home Nursing Respite, Home and Community Supports, In Home Respite and Supported Living are subject to electronic visit verification in accordance with the MS Medicaid Administrative Code. Methods for verification include GPS enabled mobile application or integrated voice recognitions (IVR) utilizing the participant's telephone or a fixed object device. Once the state's upgraded EVV solution is implemented in Summer/Fall 2023, a claims edit will be implemented to ensure claims flow appropriately from the EVV system. Exceptions to EVV policy may occur during the transition or during any system outages/unavailability. If those instances, DOM would grant exceptions in writing on an as needed basis.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The Mississippi Department of Mental Health (MDMH), the operating agency, provides Support Coordination through four (4) of the five (5) Regional Programs. One (1) Regional Program, Boswell Regional Center, provides waiver services except for Support Coordination.

Community Mental Health Centers, enrolled as waiver providers, can provide any of the approved waiver services except for Support Coordination and specialized medical supplies (catheters, disposable briefs and under pads).

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not

voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The Department of Mental Health is appropriated the state funds for this waiver. MDMH pays the state match in advance to the Division of Medicaid (DOM) via an intergovernmental transfer (IGT based on the prior quarter's claims payments.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  Check each that applies:

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

This waiver covers participants residing in residential, home and community-based care facilities. The ID/DD waiver services rendered in this waiver do not include coverage for room and board. Waiver participant records, to demonstrate the facility is not charging for room and board, are required to be maintained within provider facility and are available to auditors at all times. Such records include a copy of the person's lease and/or written financial agreements which must contain provisions specifically setting forth services and accommodations to be provided by the service provider. The written financial agreements must include the following items:

1) Basic charges agreed upon, separating costs for room and board and personal care services
2) Period of time to be covered in charges
3) List of itemized charges,
4) Agreement regarding refunds for payments
5) Language concerning the person's rights concerning eviction. People must be afforded the rights outlined in the Landlord Tenant
laws of the State of Mississippi.

Participant written financial agreements are subject to review to ensure that no Medicaid payment is made for room and board charges. The costs for room and board may not fluctuate based on the amount of Medicaid reimbursement each month.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	*Col. 2*	*Col. 3*	*Col. 4*	*Col. 5*	*Col. 6*	*Col. 7*	*Col. 8*
Year	*Factor D*	*Factor D'*	*Total: D+D'*	*Factor G*	*Factor G'*	*Total: G+G'*	*Difference (Col 7 less Column4)*
1	*52869.25*	*6485.95*	*59355.20*	*121005.96*	*4715.05*	*125721.01*	*66365.81*
2	*52869.25*	*6667.56*	*59536.81*	*124394.13*	*4847.07*	*129241.20*	*69704.39*

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
3	52869.25	6854.25	59723.50	127877.17	4982.79	132859.96	73136.46
4	52869.25	7046.17	59915.42	131457.73	5122.31	136580.04	76664.62
5	52869.25	7243.46	60112.71	135138.54	5265.73	140404.27	80291.56

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	4150	4150
Year 2	4150	4150
Year 3	4150	4150
Year 4	4150	4150
Year 5	4150	4150

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Based on the SFY2022 CMS 372 Report data, the average length of stay for this waiver is 349 days. Based on this information, it is estimated that average length of stay for waiver participants during the course of the waiver renewal period is approximately 11.7 months. Average length of stay was calculated based on SFY2022 372 data as this factor was used for all of the Appendix J assumptions. The state has reviewed ALOS for each waiver across several years and determined it to be stable year to year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Estimates of the number of persons who will be served on the waiver were based upon the sum of the current unduplicated count and the estimated need for Year 1. For each year including year 1, the estimated number of users and average units per user are based on SFY 2022 372 report data and adjusted if needed to address any projected Factor C changes from SFY 2022. Average costs per unit are based on the rate methodology outlined in Appendix I for year 1. Rates were then projected stable for years 2-5. Once the state completes the ongoing ground up rate studies, a waiver amendment will be submitted if projected cost per unit will be impacted for future periods.

The 4.4% average projected MEI was applied annually to the SFY 2022 CMS 372 report data to develop the WY1 (SFY 2024) estimates. MEI was sourced from CMS published data from Quarter 2 2021 to the Quarter 3 2023 forecast.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimates for Factor D' are based on the SFY 2022 CMS 372 report data and is trended forward to FY2024 using a 4.4% average projected MEI which was calculated based on estimated increase for Q3 2022 – Q3 2023. The 4.4% average projected MEI was applied annually to the SFY 2022 CMS 372 report data to develop the WY1 (SFY 2024) estimates. MEI was sourced from CMS published data from Quarter 2 2021 to the Quarter 3 2023 forecast (https://www/cms/gov/files/zip/market-basket-history-and-forecasts.zip). The estimate was applied for year one and every year after was adjusted based on a 2.8% average projected MEI. Projected MEI was calculated based on estimated increases for Q3 2023 – Q2 2028.

Factor G' is projected higher than Factor D' as utilization of some state plan services including hospital benefits and therapy codes may be higher for members in intermediate care facility settings who have more chronic health conditions that cannot be managed at home on the waiver.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor G is based upon DOM's analysis of intermediate care facility expenditures for FY2022 based on 372 reporting and is trended forward to FY2024 based on an 4.4% average projected MEI which was calculated based on estimated increase for Q3 2022 – Q2 2023. The 4.4% average projected MEI was applied annually to the SFY 2022 CMS 372 report data to develop the WY1 (SFY 2024) estimates. MEI was sourced from CMS published data from Quarter 2 2021 to the Quarter 3 2023 forecast (https://www/cms/gov/files/zip/market-basket-history-and-forecasts.zip).

The specific intermediate care facility expenditures analyzed were actual paid claims per Medicaid beneficiary in a ICF, including individuals with intellectual or developmental disabilities, with a similar average length of stay. Every year after was adjusted based on a 2.8% average projected MEI. Projected MEI was calculated based on estimated increases for Q3 2023 – Q2 2028.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimates for G' are based on DOM's analysis of the expenditures for all Medicaid services other than those included for Factor G for SFY 2022 based on 372 reporting and is trended forward to FY2024 based on an 4.4% average projected MEI which was calculated based on estimated increase for Q3 2022 – Q2 2023. The 4.4% average projected MEI was applied annually to the SFY 2022 CMS 372 report data to develop the WY1 (SFY 2024) estimates. MEI was sourced from CMS published data from Quarter 2 2021 to the Quarter 3 2023 forecast (https://www/cms/gov/files/zip/market-basket-history-and-forecasts.zip).

The specific expenditures analyzed were actual paid claims per Medicaid beneficiaries in a intermediate care facility, including individuals with intellectual or developmental disabilities, with a similar average length of stay. Every year after was adjusted based on a 2.8% average projected MEI. Projected MEI was calculated based on estimated increases for Q3 2023 – Q2 2028.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Day Services - Adult	
In-Home Respite	
Prevocational Services	
Supervised Living	
Support Coordination	
Supported Employment	
Supported Living	
Specialized Medical Supplies	
Therapy Services	
Behavior Support Services	
Community Respite	
Crisis Intervention	
Crisis Support	
Home and Community Supports	
Host Home	
In-Home Nursing Respite	
Job Discovery	
Shared Supported Living	
Transition Assistance	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Day Services - Adult Total:						***42698514.97***
Low Support	*15 min*	*955*	*3247.00*	*4.51*	***13984991.35***	
Medium Support	*15 min*	*1079*	*3371.00*	*4.98*	***18113798.82***	
				GRAND TOTAL:		***219407379.55***
				Total Estimated Unduplicated Participants:		***4150***
				Factor D (Divide total by number of participants):		***52869.25***
				Average Length of Stay on the Waiver:		*349*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
High Support	15 min	540	3556.00	5.52	10599724.80	
In-Home Respite Total:						17829083.95
In-Home Respite, 1 person	15 min	789	3579.00	6.19	17479513.89	
In-Home Respite, 2 person	15 min	21	3832.00	4.08	328325.76	
In-Home Respite, 3 person	15 min	10	623.00	3.41	21244.30	
Prevocational Services Total:						5042662.10
Low Support 1/2	15 min	249	665.00	14.90	2467216.50	
Medium Support 3	15 min	208	725.00	15.82	2385656.00	
High Support 4/5	15 min	21	520.00	17.38	189789.60	
Supervised Living Total:						83853654.40
4-person or fewer, low support 1/2	day	104	232.00	217.76	5254113.28	
4-person or fewer, medium support 3	day	104	254.00	239.07	6315273.12	
4-person or fewer, high support 4/5	day	21	190.00	281.69	1123943.10	
5 person or more, low support 1/2	day	415	267.00	198.47	21991468.35	
5-person or more, medium support 3	day	498	255.00	210.67	26752983.30	
5-person or more, high support 4/5	day	249	255.00	235.01	14921959.95	
Behavioral Supervised Living	day	50	205.00	544.47	5580817.50	
Medical Supervised Living	day	42	129.00	353.10	1913095.80	
Support Coordination Total:						8019460.00
Support Coordination	monthly	4150	8.00	241.55	8019460.00	
Supported Employment Total:						3837685.40
Job Development	15 min	208	276.00	10.15	582691.20	
Job Maintenance	15 min	332	990.00	9.63	3165188.40	
Job Maintenance					62331.08	

GRAND TOTAL:	219407379.55
Total Estimated Unduplicated Participants:	4150
Factor D (Divide total by number of participants):	52869.25
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
2-person	15 min	31	334.00	6.02		
Job Maintenance 3-person	15 min	21	272.00	4.81	27474.72	
Supported Living Total:						4720833.28
Intermittent 1-person	15 min	208	2791.00	7.48	4342349.44	
Intermittent 2-person	15 min	42	1827.00	4.72	362184.48	
Intermittent 3-person	15 min	42	99.00	3.92	16299.36	
Specialized Medical Supplies Total:						222876.16
Disposable briefs	each	415	426.00	0.82	144967.80	
Catheters	each	6	388.00	4.46	10382.88	
Underpads	each	332	473.00	0.43	67525.48	
Therapy Services Total:						68793.66
Occupational Therapy	15 min	2	70.00	19.17	2683.80	
Physical Therapy	15 min	21	142.00	17.83	53169.06	
Speech Therapy	15 min	4	192.00	16.85	12940.80	
Behavior Support Services Total:						4585999.20
Behavior Support Consultant- 15 min	15 min	291	516.00	21.62	3246372.72	
Behavior Support Interventionist- 15 min	15 min	62	1383.00	15.17	1300766.82	
Evaluation < 6 hours	per evaluation	21	1.00	370.10	7772.10	
Evaluation > 6 hours	per evaluation	42	1.00	740.18	31087.56	
Community Respite Total:						67399.92
Community Respite	15 min	42	516.00	3.11	67399.92	
Crisis Intervention Total:						4665.94
Intermittent - 15 min	15 min	2	67.00	7.97	1067.98	
Daily					3597.96	

GRAND TOTAL:	219407379.55
Total Estimated Unduplicated Participants:	4150
Factor D (Divide total by number of participants):	52869.25
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	day	2	3.00	599.66		
Crisis Support Total:						**423029.25**
Crisis Support	day	21	63.00	319.75	**423029.25**	
Home and Community Supports Total:						**30679111.20**
Home and Community Supports, 1-person	15 min	1328	3132.00	7.20	**29946931.20**	
Home and Community Supports, 2 person	15 min	42	3772.00	4.62	**731918.88**	
Home and Community Supports, 3 person	15 min	2	34.00	3.84	**261.12**	
Host Home Total:						**82908.00**
Host Home	day	2	300.00	138.18	**82908.00**	
In-Home Nursing Respite Total:						**9491713.92**
In-Home Nursing Respite	15 min	208	4371.00	10.44	**9491713.92**	
Job Discovery Total:						**3240.72**
Job Discovery	15 min	2	126.00	12.86	**3240.72**	
Shared Supported Living Total:						**7758947.48**
Low Support 1/2	day	145	286.00	137.81	**5714980.70**	
Medium Support 3	day	42	271.00	173.49	**1974663.18**	
High Support 4/5	day	2	155.00	223.56	**69303.60**	
Transition Assistance Total:						**16800.00**
Transition Assistance	lifetime	21	1.00	800.00	**16800.00**	

GRAND TOTAL:	**219407379.55**
Total Estimated Unduplicated Participants:	**4150**
Factor D (Divide total by number of participants):	**52869.25**
Average Length of Stay on the Waiver:	349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services - Adult Total:						**42698514.97**
Low Support	15 min	955	3247.00	4.51	**13984991.35**	
Medium Support	15 min	1079	3371.00	4.98	**18113798.82**	
High Support	15 min	540	3556.00	5.52	**10599724.80**	
In-Home Respite Total:						**17829083.95**
In-Home Respite, 1 person	15 min	789	3579.00	6.19	**17479513.89**	
In-Home Respite, 2 person	15 min	21	3832.00	4.08	**328325.76**	
In-Home Respite, 3 person	15 min	10	623.00	3.41	**21244.30**	
Prevocational Services Total:						**5042662.10**
Low Support 1/2	15 min	249	665.00	14.90	**2467216.50**	
Medium Support 3	15 min	208	725.00	15.82	**2385656.00**	
High Support 4/5	15 min	21	520.00	17.38	**189789.60**	
Supervised Living Total:						**83853654.40**
4-person or fewer, low support 1/2	day	104	232.00	217.76	**5254113.28**	
4-person or fewer, medium support 3	day	104	254.00	239.07	**6315273.12**	
4-person or fewer, high support 4/5	day	21	190.00	281.69	**1123943.10**	
5 person or more, low support 1/2	day	415	267.00	198.47	**21991468.35**	
5-person or more, medium support 3	day	498	255.00	210.67	**26752983.30**	
5-person or more, high support 4/5	day	249	255.00	235.01	**14921959.95**	
Behavioral Supervised Living	day	50	205.00	544.47	**5580817.50**	
Medical Supervised Living	day	42	129.00	353.10	**1913095.80**	
Support Coordination Total:						**8019460.00**
Support Coordination	month	4150	8.00	241.55	**8019460.00**	

GRAND TOTAL:	**219407379.55**
Total Estimated Unduplicated Participants:	**4150**
Factor D (Divide total by number of participants):	**52869.25**
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:						**3837685.40**
Job Development	15 min	208	276.00	10.15	**582691.20**	
Job Maintenance	15 min	332	990.00	9.63	**3165188.40**	
Job Maintenance 2-person	15 min	31	334.00	6.02	**62331.08**	
Job Maintenance 3-person	15 min	21	272.00	4.81	**27474.72**	
Supported Living Total:						**4720833.28**
Intermittent 1-person	15 min	208	2791.00	7.48	**4342349.44**	
Intermittent 2-person	15 min	42	1827.00	4.72	**362184.48**	
Intermittent 3-person	15 min	42	99.00	3.92	**16299.36**	
Specialized Medical Supplies Total:						**222876.16**
Disposable briefs	each	415	426.00	0.82	**144967.80**	
Catheters	each	6	388.00	4.46	**10382.88**	
Underpads	each	332	473.00	0.43	**67525.48**	
Therapy Services Total:						**68793.66**
Occupational Therapy	15 mins	2	70.00	19.17	**2683.80**	
Physical Therapy	15 min	21	142.00	17.83	**53169.06**	
Speech Therapy	15 min	4	192.00	16.85	**12940.80**	
Behavior Support Services Total:						**4585999.20**
Behavior Support Consultant- 15 min	15 min	291	516.00	21.62	**3246372.72**	
Behavior Support Interventionist- 15 min	15 min	62	1383.00	15.17	**1300766.82**	
Evaluation < 6 hours	per evaluation	21	1.00	370.10	**7772.10**	
Evaluation > 6 hours	per evaluation	42	1.00	740.18	**31087.56**	
Community Respite Total:						**67399.92**
Community Respite					**67399.92**	

GRAND TOTAL:	**219407379.55**
Total Estimated Unduplicated Participants:	**4150**
Factor D (Divide total by number of participants):	**52869.25**
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 min	42	516.00	3.11		
Crisis Intervention Total:						**4665.94**
Intermittent - 15 min	15 min	2	67.00	7.97	**1067.98**	
Daily	day	2	3.00	599.66	**3597.96**	
Crisis Support Total:						**423029.25**
Crisis Support	day	21	63.00	319.75	**423029.25**	
Home and Community Supports Total:						**30679111.20**
Home and Community Supports, 1-person	15 min	1328	3132.00	7.20	**29946931.20**	
Home and Community Supports, 2 person	15 min	42	3772.00	4.62	**731918.88**	
Home and Community Supports, 3 person	15 min	2	34.00	3.84	**261.12**	
Host Home Total:						**82908.00**
Host Home	day	2	300.00	138.18	**82908.00**	
In-Home Nursing Respite Total:						**9491713.92**
In-Home Nursing Respite	15 min	208	4371.00	10.44	**9491713.92**	
Job Discovery Total:						**3240.72**
Job Discovery	15 min	2	126.00	12.86	**3240.72**	
Shared Supported Living Total:						**7758947.48**
Low Support 1/2	day	145	286.00	137.81	**5714980.70**	
Medium Support 3	day	42	271.00	173.49	**1974663.18**	
High Support 4/5	day	2	155.00	223.56	**69303.60**	
Transition Assistance Total:						**16800.00**
Transition Assistance	lifetime	21	1.00	800.00	**16800.00**	

GRAND TOTAL:	**219407379.55**
Total Estimated Unduplicated Participants:	**4150**
Factor D (Divide total by number of participants):	**52869.25**
Average Length of Stay on the Waiver:	349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Day Services - Adult Total:						***42698514.97***
Low Support	*15 min*	*955*	*3247.00*	*4.51*	***13984991.35***	
Medium Support	*15 min*	*1079*	*3371.00*	*4.98*	***18113798.82***	
High Support	*15 min*	*540*	*3556.00*	*5.52*	***10599724.80***	
In-Home Respite Total:						***17829083.95***
In-Home Respite, 1 person	*15 min*	*789*	*3579.00*	*6.19*	***17479513.89***	
In-Home Respite, 2 person	*15 min*	*21*	*3832.00*	*4.08*	***328325.76***	
In-Home Respite, 3 person	*15 min*	*10*	*623.00*	*3.41*	***21244.30***	
Prevocational Services Total:						***5042662.10***
Low Support 1/2	*15 min*	*249*	*665.00*	*14.90*	***2467216.50***	
Medium Support 3	*15 min*	*208*	*725.00*	*15.82*	***2385656.00***	
High Support 4/5	*15 min*	*21*	*520.00*	*17.38*	***189789.60***	
Supervised Living Total:						***83853654.40***
4-person or fewer, low support 1/2	*day*	*104*	*232.00*	*217.76*	***5254113.28***	
4-person or fewer, medium support 3	*day*	*104*	*254.00*	*239.07*	***6315273.12***	
4-person or fewer, high support 4/5	*day*	*21*	*190.00*	*281.69*	***1123943.10***	
5 person or more, low support 1/2	*day*	*415*	*267.00*	*198.47*	***21991468.35***	
5-person or more, medium support 3	*day*	*498*	*255.00*	*210.67*	***26752983.30***	
5-person or more, high support 4/5	*day*	*249*	*255.00*	*235.01*	***14921959.95***	
Behavioral					***5580817.50***	

GRAND TOTAL:	***219407379.55***
Total Estimated Unduplicated Participants:	***4150***
Factor D (Divide total by number of participants):	***52869.25***
Average Length of Stay on the Waiver:	*349*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supervised Living	day	50	205.00	544.47		
Medical Supervised Living	day	42	129.00	353.10	1913095.80	
Support Coordination Total:						8019460.00
Support Coordination	month	4150	8.00	241.55	8019460.00	
Supported Employment Total:						3837685.40
Job Development	15 min	208	276.00	10.15	582691.20	
Job Maintenance	15 min	332	990.00	9.63	3165188.40	
Job Maintenance 2-person	15 min	31	334.00	6.02	62331.08	
Job Maintenance 3-person	15 min	21	272.00	4.81	27474.72	
Supported Living Total:						4720833.28
Intermittent 1-person	15 min	208	2791.00	7.48	4342349.44	
Intermittent 2-person	15 min	42	1827.00	4.72	362184.48	
Intermittent 3-person	15 min	42	99.00	3.92	16299.36	
Specialized Medical Supplies Total:						222876.16
Disposable briefs	each	415	426.00	0.82	144967.80	
Catheters	each	6	388.00	4.46	10382.88	
Underpads	each	332	473.00	0.43	67525.48	
Therapy Services Total:						68793.66
Occupational Therapy	15 min	2	70.00	19.17	2683.80	
Physical Therapy	15 min	21	142.00	17.83	53169.06	
Speech Therapy	15 min	4	192.00	16.85	12940.80	
Behavior Support Services Total:						4585999.20
Behavior Support Consultant- 15 min	15 min	291	516.00	21.62	3246372.72	
Behavior Support Interventionist- 15	15 min	62	1383.00	15.17	1300766.82	

GRAND TOTAL:	219407379.55
Total Estimated Unduplicated Participants:	4150
Factor D (Divide total by number of participants):	52869.25
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
min						
Evaluation < 6 hours	per evaluation	21	1.00	370.10	7772.10	
Evaluation > 6 hours	per evaluation	42	1.00	740.18	31087.56	
Community Respite Total:						67399.92
Community Respite	15 min	42	516.00	3.11	67399.92	
Crisis Intervention Total:						4665.94
Intermittent - 15 min	15 min	2	67.00	7.97	1067.98	
Daily	day	2	3.00	599.66	3597.96	
Crisis Support Total:						423029.25
Crisis Support	day	21	63.00	319.75	423029.25	
Home and Community Supports Total:						30679111.20
Home and Community Supports, 1-person	15 min	1328	3132.00	7.20	29946931.20	
Home and Community Supports, 2 person	15 min	42	3772.00	4.62	731918.88	
Home and Community Supports, 3 person	15 min	2	34.00	3.84	261.12	
Host Home Total:						82908.00
Host Home	day	2	300.00	138.18	82908.00	
In-Home Nursing Respite Total:						9491713.92
In-Home Nursing Respite	15 min	208	4371.00	10.44	9491713.92	
Job Discovery Total:						3240.72
Job Discovery	15 min	2	126.00	12.86	3240.72	
Shared Supported Living Total:						7758947.48
Low Support 1/2	day	145	286.00	137.81	5714980.70	
Medium Support 3	day	42	271.00	173.49	1974663.18	
High Support 4/5	day	2	155.00	223.56	69303.60	

GRAND TOTAL:	219407379.55
Total Estimated Unduplicated Participants:	4150
Factor D (Divide total by number of participants):	52869.25
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Assistance Total:						**16800.00**
Transition Assistance	lifetime	21	1.00	800.00	**16800.00**	

GRAND TOTAL:	**219407379.55**
Total Estimated Unduplicated Participants:	**4150**
Factor D (Divide total by number of participants):	**52869.25**
Average Length of Stay on the Waiver:	349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services - Adult Total:						**42698514.97**
Low Support	15 min	955	3247.00	4.51	**13984991.35**	
Medium Support	15 min	1079	3371.00	4.98	**18113798.82**	
High Support	15 min	540	3556.00	5.52	**10599724.80**	
In-Home Respite Total:						**17829083.95**
In-Home Respite, 1 person	15 min	789	3579.00	6.19	**17479513.89**	
In-Home Respite, 2 person	15 min	21	3832.00	4.08	**328325.76**	
In-Home Respite, 3 person	15 min	10	623.00	3.41	**21244.30**	
Prevocational Services Total:						**5042662.10**
Low Support 1/2	15 min	249	665.00	14.90	**2467216.50**	
Medium Support 3	15 min	208	725.00	15.82	**2385656.00**	
High Support 4/5	15 min	21	520.00	17.38	**189789.60**	
Supervised Living Total:						**83853654.40**

GRAND TOTAL:	**219407379.55**
Total Estimated Unduplicated Participants:	**4150**
Factor D (Divide total by number of participants):	**52869.25**
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
4-person or fewer, low support 1/2	day	104	232.00	217.76	5254113.28	
4-person or fewer, medium support 3	day	104	254.00	239.07	6315273.12	
4-person or fewer, high support 4/5	day	21	190.00	281.69	1123943.10	
5 person or more, low support 1/2	day	415	267.00	198.47	21991468.35	
5-person or more, medium support 3	day	498	255.00	210.67	26752983.30	
5-person or more, high support 4/5	day	249	255.00	235.01	14921959.95	
Behavioral Supervised Living	day	50	205.00	544.47	5580817.50	
Medical Supervised Living	day	42	129.00	353.10	1913095.80	
Support Coordination Total:						8019460.00
Support Coordination	month	4150	8.00	241.55	8019460.00	
Supported Employment Total:						3837685.40
Job Development	15 min	208	276.00	10.15	582691.20	
Job Maintenance	15 min	332	990.00	9.63	3165188.40	
Job Maintenance 2-person	15 min	31	334.00	6.02	62331.08	
Job Maintenance 3-person	15 min	21	272.00	4.81	27474.72	
Supported Living Total:						4720833.28
Intermittent 1-person	15 min	208	2791.00	7.48	4342349.44	
Intermittent 2-person	15 min	42	1827.00	4.72	362184.48	
Intermittent 3-person	15 min	42	99.00	3.92	16299.36	
Specialized Medical Supplies Total:						222876.16
Disposable briefs	each	415	426.00	0.82	144967.80	
Catheters	each	6	388.00	4.46	10382.88	
Underpads	each	332	473.00	0.43	67525.48	

GRAND TOTAL:	219407379.55
Total Estimated Unduplicated Participants:	4150
Factor D (Divide total by number of participants):	52869.25
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy Services Total:						**68793.66**
Occupational Therapy	15 min	2	70.00	19.17	**2683.80**	
Physical Therapy	15 min	21	142.00	17.83	**53169.06**	
Speech Therapy	15 min	4	192.00	16.85	**12940.80**	
Behavior Support Services Total:						**4585999.20**
Behavior Support Consultant- 15 min	15 min	291	516.00	21.62	**3246372.72**	
Behavior Support Interventionist- 15 min	15 min	62	1383.00	15.17	**1300766.82**	
Evaluation < 6 hours	per evaluation	21	1.00	370.10	**7772.10**	
Evaluation > 6 hours	per evaluation	42	1.00	740.18	**31087.56**	
Community Respite Total:						**67399.92**
Community Respite	15 min	42	516.00	3.11	**67399.92**	
Crisis Intervention Total:						**4665.94**
Intermittent - 15 min	15 min	2	67.00	7.97	**1067.98**	
Daily	day	2	3.00	599.66	**3597.96**	
Crisis Support Total:						**423029.25**
Crisis Support	day	21	63.00	319.75	**423029.25**	
Home and Community Supports Total:						**30679111.20**
Home and Community Supports, 1-person	15 min	1328	3132.00	7.20	**29946931.20**	
Home and Community Supports, 2 person	15 min	42	3772.00	4.62	**731918.88**	
Home and Community Supports, 3 person	15 min	2	34.00	3.84	**261.12**	
Host Home Total:						**82908.00**
Host Home	day	2	300.00	138.18	**82908.00**	
In-Home Nursing Respite Total:						**9491713.92**
In-Home Nursing					**9491713.92**	

GRAND TOTAL:	**219407379.55**
Total Estimated Unduplicated Participants:	**4150**
Factor D (Divide total by number of participants):	**52869.25**
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	15 min	208	4371.00	10.44		
Job Discovery Total:						**3240.72**
Job Discovery	15 min	2	126.00	12.86	**3240.72**	
Shared Supported Living Total:						**7758947.48**
Low Support 1/2	day	145	286.00	137.81	**5714980.70**	
Medium Support 3	day	42	271.00	173.49	**1974663.18**	
High Support 4/5	day	2	155.00	223.56	**69303.60**	
Transition Assistance Total:						**16800.00**
Transition Assistance	lifetime	21	1.00	800.00	**16800.00**	

GRAND TOTAL:	**219407379.55**
Total Estimated Unduplicated Participants:	**4150**
Factor D (Divide total by number of participants):	**52869.25**
Average Length of Stay on the Waiver:	349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services - Adult Total:						**42698514.97**
Low Support	15 min	955	3247.00	4.51	**13984991.35**	
Medium Support	15 min	1079	3371.00	4.98	**18113798.82**	
High Support	15 min	540	3556.00	5.52	**10599724.80**	
In-Home Respite Total:						**17829083.95**
In-Home Respite, 1 person	15 min	789	3579.00	6.19	**17479513.89**	

GRAND TOTAL:	**219407379.55**
Total Estimated Unduplicated Participants:	**4150**
Factor D (Divide total by number of participants):	**52869.25**
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Respite, 2 person	15 min	21	3832.00	4.08	328325.76	
In-Home Respite, 3 person	15 min	10	623.00	3.41	21244.30	
Prevocational Services Total:						5042662.10
Low Support 1/2	15 min	249	665.00	14.90	2467216.50	
Medium Support 3	15 min	208	725.00	15.82	2385656.00	
High Support 4/5	15 min	21	520.00	17.38	189789.60	
Supervised Living Total:						83853654.40
4-person or fewer, low support 1/2	day	104	232.00	217.76	5254113.28	
4-person or fewer, medium support 3	day	104	254.00	239.07	6315273.12	
4-person or fewer, high support 4/5	day	21	190.00	281.69	1123943.10	
5 person or more, low support 1/2	day	415	267.00	198.47	21991468.35	
5-person or more, medium support 3	day	498	255.00	210.67	26752983.30	
5-person or more, high support 4/5	day	249	255.00	235.01	14921959.95	
Behavioral Supervised Living	day	50	205.00	544.47	5580817.50	
Medical Supervised Living	day	42	129.00	353.10	1913095.80	
Support Coordination Total:						8019460.00
Support Coordination	monthly	4150	8.00	241.55	8019460.00	
Supported Employment Total:						3837685.40
Job Development	15 min	208	276.00	10.15	582691.20	
Job Maintenance	15 min	332	990.00	9.63	3165188.40	
Job Maintenance 2-person	15 min	31	334.00	6.02	62331.08	
Job Maintenance 3-person	15 min	21	272.00	4.81	27474.72	
Supported Living Total:						4720833.28
Intermittent 1-					4342349.44	

GRAND TOTAL:	219407379.55
Total Estimated Unduplicated Participants:	4150
Factor D (Divide total by number of participants):	52869.25
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
person	15 min	208	2791.00	7.48		
Intermittent 2-person	15 min	42	1827.00	4.72	362184.48	
Intermittent 3-person	15 min	42	99.00	3.92	16299.36	
Specialized Medical Supplies Total:						222876.16
Disposable briefs	each	415	426.00	0.82	144967.80	
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Community Respite Total:						67399.92
Community Respite	15 min	42	516.00	3.11	67399.92	
Crisis Intervention Total:						4665.94
Intermittent - 15 min	15 min	2	67.00	7.97	1067.98	
Daily	day	2	3.00	599.66	3597.96	
Crisis Support Total:						423029.25
Crisis Support	day	21	63.00	319.75	423029.25	
Home and Community Supports Total:						30679111.20

GRAND TOTAL:	219407379.55
Total Estimated Unduplicated Participants:	4150
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Host Home Total:						82908.00
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Job Discovery Total:						3240.72
Job Discovery	15 min	2	126.00	12.86	3240.72	
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Low Support 1/2	day	145	286.00	137.81	5714980.70	
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Transition Assistance Total:						16800.00
Transition Assistance	lifetime	21	1.00	800.00	16800.00	

GRAND TOTAL:	219407379.55
Total Estimated Unduplicated Participants:	4150
Factor D (Divide total by number of participants):	52869.25
Average Length of Stay on the Waiver:	349